Concierge Pharmacy Service Request Form

Please send this to the Concierge Pharmacy at 10MP to **FAX # 4.4686**

Hours of Operation: Mon – Friday 8AM - 4:30PM | Phone # 4.6267

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1. **Patient name: _____ Room #: _____**

   Language: English_____ Spanish _____ Other_____

Anticipated date/time of departure: _____

Number of Rxs: _____ Rxs Electronically Sent: ☐ Yes ☐ No

☐ Review complete medication list with patient

Method of Payment: ☐ Cash ☐ Check ☐ Card (credit/debit)

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2. **Please check mode of service:**

☐ Pharmacy to deliver Rxs to patient room no later than:

☐ 10:00 AM **☐ 2:00 PM**

☐ 12:00 PM **☐ 4:00 PM**

**Please allow at least one hour for delivery to patient room.*

☐ **Patient will pick-up Rxs at 10MP at _____** (MWF 7:30A-6P, TTh 7:30A-8P or Sat 8:30A-1P)

**If picking-up, patient must surrender all hard copies to pharmacy at pick-u in order to receive Rx(s).*

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3. **Name of person faxing Rxs: _____**

   Contact phone number/pager if questions: _____