Cape Ann Medical Center

Prescription Refill Form

Patient Name: ____

Date of Birth: ___________________________

Phone (best contact): _____________________________________

Name of Primary Care Physician: ___________________________

Medication Name: ____

Dosage: __________ mg   Directions (#times per day) _________

Quantity ______________

Pharmacy Name: ____

Pharmacy Location: _______________________________________

Pharmacy Phone: ____

Written to send away? [ ] YES [ ] NO
Pick up or mail? [ ] Pick up [ ] Mail

Please return this form to the office

Allow 24 hours for processing