The Endocrine Clinic, P.C.
5659 South Rex Road
Memphis, TN. 38119
Phone:901.763.3636
Fax: 901.507.0365

PRESCRIPTION REQUEST FORM

PRINT this form and fill it out, then fax it to us.

Please provide complete information and allow 48 hours for processing of your request. Only medication(s) prescribed by our providers will be filled after provider approval. Please contact your pharmacy to see if your medication is ready for pick up. Calls concerning this request or incomplete information will delay processing. Find the picture of a printer in the upper left corner of this form and click on it to print. Thanks!

Date: ______________________ (MR# ____________________[office use])

Name:________________________________ Date of Birth:________________

Home Phone Number: ______________________ ☐ (check the preferred number)
Work Phone Number: ______________________ ☐
Cell Phone Number: ______________________ ☐

Select One of These Options:
☐ Called to the pharmacy (PHONE NUMBER REQUIRED): ____________________
☐ Faxed to the pharmacy (FAX # REQUIRED): ____________________
☐ Written prescription mailed to your address (ADDRESS): ____________________

Select One of These Options:
Do you need a: ☐ **30 day** or ☐ **90 day** supply?
We will usually give a **1 year supply** from your last visit. If it has been more than a year since your last visit, you will need to be seen before your prescription will be able to be filled.

The Endocrine Clinic, P.C.
Endocrinology and Diabetes of Adults and Children

Name of Medication	Dose Strength	How many times a day you take this medication

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Office Use Only

Approved: ____________________________ Date: ______________________

Completed: ____

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