

Referring Clinic Name: \_\_\_\_\_

**STEP 1 – PATIENT SECTION**Patient Name \_\_\_\_\_ Date     /    /      
*mm dd yyyy*Date of Birth     /    /     Patient ID/SSN \_\_\_\_\_  
*mm dd yyyy*

Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Annual Household Income \_\_\_\_\_ # of People in Household \_\_\_\_\_  M  F

Phone \_\_\_\_\_

Food/Medications you are allergic to \_\_\_\_\_

Other Medications you are taking and Medical Conditions \_\_\_\_\_

**Shipping address if different from above:**  
Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PLEASE NOTE THAT CONTROLLED SUBSTANCES CANNOT BE SHIPPED TO A P. O. BOX OR DOCTOR'S OFFICE. YOU MUST ENCLOSE A COPY OF A PHOTO ID AND SOCIAL SECURITY CARD/GREEN CARD IF YOU ARE ORDERING A CONTROLLED SUBSTANCE. MEDICATIONS WILL SHIP WITHIN 10-14 DAYS.****STEP 2 – PHYSICIAN SECTION****PLEASE DO NOT USE FORM BELOW FOR CONTROLLED SUBSTANCES – ATTACH SEPARATE PRESCRIPTION.****Rx 1 –** Drug Name \_\_\_\_\_ Strength \_\_\_\_\_  
Directions \_\_\_\_\_ Quantity  90 Days  180 Days Refills (Check One)  1  2  3**Rx 2 –** Drug Name \_\_\_\_\_ Strength \_\_\_\_\_  
Directions \_\_\_\_\_ Quantity  90 Days  180 Days Refills (Check One)  1  2  3**Rx 3 –** Drug Name \_\_\_\_\_ Strength \_\_\_\_\_  
Directions \_\_\_\_\_ Quantity  90 Days  180 Days Refills (Check One)  1  2  3**PHYSICIAN MUST SIGN BELOW. PLEASE ATTACH ANY ADDITIONAL PRESCRIPTIONS TO THIS FORM.**\_\_\_\_\_  
SUBSTITUTION PERMITTED (Physician Signature)     /    /     Dispense as Written  
*mm dd yyyy*  
Physician Name \_\_\_\_\_ DEA Number \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_**STEP 3 – PAYMENT INSTRUCTIONS****Payment Options:** Check or Money Order payable to Rx Outreach, or Credit Card (Visa, MasterCard or Discover only).  
Please do not send cash.**Payment Amount:** Please refer to drug list and prices on the reverse side.Credit Card Number: \_\_\_\_\_  Visa  MasterCard  Discover  
Expiration Date     /    Event Code  
**900**

I authorize Rx Outreach to charge this credit card for payment:

**Name on Card:** \_\_\_\_\_ **Card Holder Signature** \_\_\_\_\_**Mail Form and Payment to:**

Rx Outreach / P. O. Box 66536 / St. Louis, MO 63166-6536

Rx Outreach is a fully licensed pharmacy. Rx Outreach reserves the right to add or delete medicines available, change fees, or discontinue the program at any time. Rx Outreach does not accept returns of unused medicine dispensed pursuant to a valid prescription or refund fees for any such prescription. You are responsible for the package upon delivery. All prescriptions are evaluated by a pharmacist before being filled. The quantity may be limited based on dose restrictions set by therapeutic guidelines and state regulations. We cannot ship controlled substances to a P. O. Box or doctor's office. Your shipping address for these must be a deliverable U. S. Postal Service street address.  
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