Prescription Drug Form (optional):

Name:______________________________

Current Pharmacy:_____________________ **Willing to Switch? Yes:** ☐ **No:** ☐

Drug name:	**Generic**: **Namebrand**:	Is it a tablet, capsule, cream*? **Circle one**	**Dosage**?	**Frequency?**
Drug name:	**Generic**: **Namebrand**:	Is it a tablet, capsule, cream*? **Circle one**	**Dosage**?	**Frequency?**
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*** If cream/lotion/ointment, please specify size of container/tube in 3rd column.**

Signature:________________________________ **Date**:_______________