Employee Pharmacy

Refill Transfer Request

Patient Name _____

Patient Date of Birth_____

Patient Allergies _____

Patient Phone Number _____

Do you want to be signed up for text messages? Yes____ No ____

Pharmacy Name_____

Pharmacy Phone Number _____

Medication to Be transferred	RX Number (if available)	Prescribers Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please note:

- NYS does not allow the transfer of controlled substances
- Only one refill may be transferred at a time

If your prescription does not have refills, do you want us to contact your provider for a new prescription? _____Yes _____No

Please bring this form to the Employee Pharmacy or fax it to 585-276-2600