Name:__________________________________ **Phone:**_____________________ **Date:**___________________

Address:______________________________________ **City:**________________________ **Zip Code:** ______________

Email:____ **CURRENT PLAN**______________________________________

Pharmacy Choice #1_____________________ **Pharmacy Choice #2**____________________ **Mail Order: Yes**___**No**____

SEPARATE SHEETS PER PERSON TO AVOID DELAYS PLEASE

Medication Name	Dosage	Daily Quantity*	Monthly Quantity*	Is Generic OK? Yes or No
DRUG LIST ID: __________________________ **PASSWORD DATE:** _____/_____/_____				

*** If you take pills only "as needed" please put the average quantity you use per month/year to complete this**

*** If you use insulin, indicate how many pens or vials per month**

*** If you use a cream or gel, indicate how many tubes or bottles (and what size) per year**

*** If you use inhalers, indicate how many per month/year**

PLEASE DO NOT SEND MORE THAN ONE COPY
(EMAIL, FAX OR SNAIL MAIL)