HALL-GARCIA CARDIOLOGY ASSOCIATES

PATIENT PHARMACY FORM

Hall-Garcia Cardiology Associates will now fill all newly prescribed medications and refills electronically. Please complete the following information regarding your pharmacy so we may be able to provide you with your medications.

NOTE THAT ALL PRESCRIPTIONS WILL BE SUBMITTED WITHIN 48 HOURS

Patient Name: _____ Date of Birth: _____

Physician: _____ Home Zip Code: _____

Pharmacy Name: _____ Pharmacy Phone: _____

List all current medications and place check marks by **cardiac medications only** needing refills.

☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

I consent to Hall-Garcia Cardiology Associates reviewing my medication history to aid in providing my prescriptions and their refills.

Patient Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

New medications prescribed at this visit:

_____

_____

Physician Signature: _____ Date: _____