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MEDICATION LIST UPON ADMISSION TO AFC

PATIENT NAME: _____ Today's date: _____

Patient's Date of Birth: _____

Please list any allergies (including the reaction) or indicate "NO KNOWN DRUG ALLERGIES"

Allergy: _____ Reaction: _____

Please list all current medications with dosages: (name, strength and how often taken)

(Example) Motrin	800mg	Once every morning

Local Pharmacy Information:

Local Pharmacy Name: _____

Local Pharmacy Address: _____

Local Pharmacy Phone: _____ Local Pharmacy Fax: _____

Mail Order Pharmacy Information:

Name: (Medco, CareMark, Express Scripts, etc): _____

The Pharmacy Card Number: _____

The spelling of your name on the card: _____