PRESCRIPTION REFILL EMAIL REQUEST FORM

Fill out completely and **email** to BerrieRX@cumc.columbia.edu

All prescriptions will be transmitted electronically directly to your retail or mail order pharmacy so **please fill out all fields about pharmacy below**.

Date _____

Patient Information

Last Name_____ First Name _____
Date of Birth _____Email Address _____Doctor_____
Street Address _____ City _____State ____Zip_____
Cell Phone_____ Work Phone_____Home Phone _____

Pharmacy Information (all info must be provided)

Name_____
Street Address _____City _____State _____Zip_____
Phone_____ [Fax (if known)_____]

Prescription Refill #1

Exact Name_____ Dose (mg/units) _____
Directions _____ ☐1 month or ☐3 months supply

Prescription Refill #2

Exact Name_____ Dose (mg/units) _____
Directions _____ ☐1 month or ☐3 months supply

Prescription Refill #3

Exact Name_____ Dose (mg/units) _____
Directions _____ ☐1 month or ☐3 months supply

Prescription Refill #3

Exact Name_____ Dose (mg/units) _____
Directions _____ ☐1 month or ☐3 months supply

Additional Information: _____