

Landstuhl Regional Medical Center Pharmacy

WILL CALL FORM

No ticket and No waiting required. Drop off in the designated box.

<p>PATIENT'S Name _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> <i>Last</i> <i>First</i> <i>MI</i> </div> </p> <p>PATIENT'S DoD ID Number _____</p> <p>PATIENT'S Allergies _____</p> <p>Contact Info: Best number to reach you at in case the pharmacy has a question for you: _____</p>	<p>Date/Time Prescription(s) Dropped-Off</p> <p>Date _____ / _____ / _____ <small>Month Day Year</small></p> <p>Time: _____</p>																																
<p>Please complete information below depending on the type of prescription(s).</p>																																	
<p><input type="checkbox"/> New prescriptions entered by your MTF (LRMC, etc) provider <i>If known, please provide:</i> Number of prescriptions you are expecting: _____ Provider's name: _____ Clinic: _____</p> <p><input type="checkbox"/> Paper prescription(s) from non-MTF (outside) provider: Attach the paper prescription(s) with this form</p> <p><input type="checkbox"/> Refill Prescriptions: All LRMC Pharmacies offer a convenient refill option through phone-in system at DSN 486-5601 and Commercial 06371865601. We ask that you please NOT PLACE EMPTY BOTTLES IN THE DROP BOX.</p> <p><input type="checkbox"/> Check this box if you want to pick up from ScriptCenter (Refill(s) Only)</p>	<p style="color: red; font-weight: bold;">Your prescription(s) will be ready by 1400 <u>the next business day on Monday through Friday</u></p>																																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">MEDICATION NAME OR PRESCRIPTION NUMBER</th> <th style="width: 50%;">MEDICATION NAME OR PRESCRIPTION NUMBER</th> </tr> </thead> <tbody> <tr><td>1)</td><td>16)</td></tr> <tr><td>2)</td><td>17)</td></tr> <tr><td>3)</td><td>18)</td></tr> <tr><td>4)</td><td>19)</td></tr> <tr><td>5)</td><td>20)</td></tr> <tr><td>6)</td><td>21)</td></tr> <tr><td>7)</td><td>22)</td></tr> <tr><td>8)</td><td>23)</td></tr> <tr><td>9)</td><td>24)</td></tr> <tr><td>10)</td><td>25)</td></tr> <tr><td>11)</td><td>26)</td></tr> <tr><td>12)</td><td>27)</td></tr> <tr><td>13)</td><td>28)</td></tr> <tr><td>14)</td><td>29)</td></tr> <tr><td>15)</td><td>30)</td></tr> </tbody> </table>	MEDICATION NAME OR PRESCRIPTION NUMBER	MEDICATION NAME OR PRESCRIPTION NUMBER	1)	16)	2)	17)	3)	18)	4)	19)	5)	20)	6)	21)	7)	22)	8)	23)	9)	24)	10)	25)	11)	26)	12)	27)	13)	28)	14)	29)	15)	30)	
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