



**Prescription Transfer Request Form**

This transfer request authorizes Haskell Regional Hospital - Outpatient Pharmacy (HRH - OP) to transfer prescriptions on my behalf from the pharmacy listed below to HRH - OP.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Drug Allergies:  No Known Drug Allergies  
 List Drug Allergies \_\_\_\_\_

Pharmacy: \_\_\_\_\_ 2<sup>nd</sup> Pharmacy: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Medication List: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check Here  Transfer any additional medications I may have on file

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Notes to HRH - OP Staff: