HealthScripts
OF AMERICA - OKLAHOMA CITY, LLC

Prescription Transfer Form

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ Patient's Phone #: _____

Patient's City, State, and Zip: _____

Medication Allergies: _____

_____

Please list any medications you would like transferred:

☐ All medications from the pharmacy(s) listed below.

Or please list the individual medications and there prescription number.

1. _____ Rx#:_____
2. _____ Rx#:_____
3. _____ Rx#:_____
4. _____ Rx#:_____
5. _____ Rx#:_____
6. _____ Rx#:_____
7. _____ Rx#:_____
8. _____ Rx#:_____

Pharmacy(s) you would like your medications transferred from:

Pharmacy Name: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

Please sign below authorizing us to transfer the above prescriptions from the pharmacies you've provided to us.

Signature: _____ Date: _____

Please send us this form via fax to 405-636-4266, or email to HOAOKCity@hsrxa.com, or by calling us at 405-636-4236, or dropping it off at our pharmacy location:

804 West Interstate 240 Service Road Suite F, Oklahoma City, OK 73139