



Prescription Transfer Form

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

Patient's City, State, and Zip: _____ Patient's Phone #: _____

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 405-605-3588, or email to GetPharMoreInfo@gmail.com, or by calling us at 405-604-6861, or dropping it off at our pharmacy location: 3330 NW 56th Street, Suite 100, Oklahoma City, OK 73112.