POTOMAC GROVE PSYCHIATRY DR. LOUIS E. KOPOLOW

DATE:_____ **MEDICATION FORM**

INITIAL FORM (CIRCLE YES or NO) Y N REFILL REQUEST (CIRCLE Yes or No) Y N

PLEASE COMPLETE THE FORM WHEN YOU REQUEST A REFILL **AND** UPDATE YOUR INFORMATION!

WITHOUT THE INFORMATION DR. KOPOLOW WILL BE UNABLE TO HANDLE YOUR REQUEST.

Patient Name:_____DOB:_____Phone:_____

Address:_____

MEDICATION	DOSE	QUANTITY	DIRECTIONS

THIS SECTION MUST BE COMPLETED IN ORDER TO PROCESS YOUR PRESCRIPTIONS:

NAME OF PHARMACY: _____

ADDRESS OF PHARMACY: _____

PHONE NUMBER OF PHARMACY: _____

INSURANCE INFORMATION…….

IF AUTHORIZATION IS REQUIRED -Get code from pharmacy for Dr. Kopolow

INSURANCE CO: _____

POLICY OR MEMBER ID: _____

INSURANCE PHARMACY PHONE NUMBER: _____

PLEASE EMAIL COMPLETED FORM TO: admin1@pgpmd.com

Reminder!!! Please allow a 24-72 hour time! Be sure to check your supply of medications in ADVANCE of your running out of medication. * Be sure to watch for a new policy about medication requests.**