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Out of State Prescription Request Form

Date of request:_____
Patient name: _____
Patient DOB: _____
Medication name: _____ Dose: _____
Frequency:_____

Out of state pharmacy information

Address: _____
Phone number: _____
Fax number: _____

Detailed reason for requesting medication be sent to an out of state pharmacy

_____
_____
_____

Length of time you will be out of state: _____

I understand that the turnaround time for this request is 5 business days and I will not be able to request an urgent review per Innovative Psychiatry's office policies. I also understand that this request may be denied due to the nature of the request and/or the state of the requested pharmacy as some states do not accept out of state prescriptions. I understand that it is at the sole discretion of my provider to send out of state prescriptions. I understand that if my request is denied, I will be provided with a recommendation on what to do to avoid a gap in medication and will be urged to follow that recommendation.

Patient Signature: _____

For office use only

Approved _____ Denied _____ Recommendation: