Tuxedo Pharmacy

164 W. Wieuca Road, Suite #7
Atlanta, Georgia 30342
Phone: 404.255.3022 Fax: 404.843.3707
Email: buckheadpharmacy@gmail.com

Transfer/Refill Request Form

Patient Information:

Patient's Name: _____ Patient's Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Number: _____ Mobile Number: _____
Known Allergies: _____
Health Conditions: _____

Prescription Information:

If you don't have the prescription number, leave blank.

Rx Number: _____ Medication/Dosage: _____ Quantity: _____
Rx Number: _____ Medication/Dosage: _____ Quantity: _____
Rx Number: _____ Medication/Dosage: _____ Quantity: _____
Rx Number: _____ Medication/Dosage: _____ Quantity: _____
Rx Number: _____ Medication/Dosage: _____ Quantity: _____
Over the Counter Items: _____

Where is the prescription currently being filled? _____ Location: _____
Telephone: _____

Additional Pharmacy or Prescription Information: _____

If you need the pharmacist to get a new prescriptions from your physician, please provide your doctor's name, phone number, and any medications: _____

Requested Fill Date: _____
Pick-Up: _____ Delivery: _____

Child Proof Lids: _____
Easy Open Lids: _____
Bubble Packaging: _____