Oakland Orthopedic Partners, P.C., *offices of*
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Prescription Transmission Form

Dear Patient, for your convenience and safety, we offer a computerized prescription program that will improve both the accuracy and convenience of prescribing medications.

What electronic transmission means to you:

- Prescriptions will be sent directly to the main pharmacy, reducing your wait time at the pharmacy
- Faster transmission of your prescription to mail order pharmacies

To implement this program, we need to collect some information from you:

- Your main pharmacy
- Additional pharmacies to be used as an alternative
- Mail order benefit program if applicable

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) as any information provided will be helpful.

Patient's Name ______________________________

Patient Address ______________________________

Main pharmacy

Name (i.e. CVS, Rite Aid, etc.) ______________________________

Street Name & City ______________________________

Phone ______________________ Fax ______________________

Additional pharmacies you would like to keep on file

Name (i.e. CVS, Rite Aid, etc.) ______________________________

Street Name & City ______________________________

Phone ______________________ Fax ______________________

Name (i.e. CVS, Rite Aid, etc.) ______________________________

Street Name & City ______________________________

Phone ______________________ Fax ______________________

Please list your drug allergies ______________________________

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