# NORTH SHORE DIABETES AND ENDOCRINE ASSOCIATES

**TO EXPEDITE YOUR VISIT TODAY, PLEASE LIST THE NAMES OF THE PRESCRIPTIONS YOU REQUIRE. PLEASE INCLUDE ALL MEDICATIONS EVEN IF THOSE MEDICATIONS ARE PRESCRIBED BY ANOTHER PHYSICIAN.**

**PLEASE RETURN THIS FORM TO THE RECEPTIONIST OR THE MEDICAL ASSISTANT WINDOW.**

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**PATIENT NAME**_____

**DATE OF VISIT**_____**PHYSICIAN**_____

| PRESCRIPTION | DOSE | DIRECTIONS | REFILLS TODAY? (CIRCLE YES OR NO) | CORRECTION (DR. USE ONLY) |
|---|---|---|---|---|
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |
| | | | YES NO | |

**PHARMACY INFORMATION:**

**Pharmacy name:** _____

**Pharmacy address:** _____

**Pharmacy Phone number:** _____

**MAIL ORDER PHARMACY:**

**Do you use a mail order pharmacy?** **YES** **NO**

**If yes, name of mail order pharmacy:** _____