Colorado Children's Ear, Nose & Throat, P.C.

Prescription Call In Form

PATIENT FULL NAME: ____

Date of Birth: _____/ _____/ _____ Date of Request: ______________________

Home Phone with Area Code: (   ) __________________

Work Phone with Area Code: (   ) __________________

Drug Allergies: Yes / No

If Yes, what drugs: ________________________________

Weight in Pounds or Kilograms: ___________Please indicate which: Lbs. or Kgs.

Reason you are calling in/Past History?

____

____

Post operative? Yes / No

If Yes, what was your Procedure and Date:

____

Needs Refill: Liquid /Chewable Tablets / Tabs

Drug Preferred: ____

Pharmacy Name: ____

Pharmacy Phone Number: ____

Patient's Signature or Responsible Party Signature: _________________________

Relationship of Responsible Party to Patient: ______________________________

Please Note: If you have not been seen by CCENT within the last 90 days you will need a follow-up appointment before your prescription can be filled. If this is an urgent request please call the office. You will need to fax your request to CCENT, P.C. at (303) 347 - 1140.

OFFICE USE ONLY:

Dosage: ___________MG ______________ CC FREQ: QD / BID / TID / QID

Total Amount Prescribed: _______________CC / ____________________Tabs

Total Days: ______________ Refill #: 0 / 1 / 2 / 3 Date /Time Called In: ________________