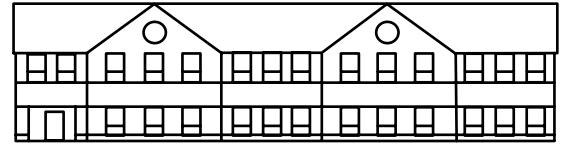


**Family Physicians of Gahanna, Inc.**  
535 Offcenter Pl. • Gahanna, Ohio 43230  
(614) 471-9654 • fax (614) 471-9634  
www.fpoginc.com • info@fpoginc.com



## Refill Request Fax Form

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Prescription Type:**

- Pick up at office: pharmacy information **not required**
- Call in to pharmacy: pharmacy information **required**

### Patient Information

**All fields are required.**

**Patient's Name:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Patient's Daytime Phone:** (\_\_\_\_) \_\_\_\_\_

### Medication Information

**All fields in bold type are required.**

**Name of Medication:** \_\_\_\_\_

**Strength of Medication:** \_\_\_\_\_

Quantity Requested: \_\_\_\_\_

**Prescribing Doctor:** \_\_\_\_\_

**Dosage Directions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Pharmacy Information

**Both fields required if prescription is to be called into a pharmacy.**

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone Number: (\_\_\_\_) \_\_\_\_\_

### Additional Comments or Instructions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Fax this form to (614) 473-0666.**