Client Drug List

Name:___________________________________

Date:____________________________________

Phone:___________________________________

County:________________**Zip Code:**__________

Primary Agent:____________________________

***Do not list over-the-counter medications**
***Only list medications you fill at your pharmacy**

DRUG LIST

Name of Prescription Medication (As it reads on your bottle)	Dose (mg)	How many times a day?	Do you receive a 30 or 90 day fill?
1.___________________	________	________	________
2.___________________	________	________	________
3.___________________	________	________	________
4.___________________	________	________	________
5.___________________	________	________	________
6.___________________	________	________	________
7.___________________	________	________	________
8.___________________	________	________	________
9.___________________	________	________	________
10.__________________	________	________	________

(List additional medications on back)

Do you have VA? ___Y___N

Do you have Medicaid? ___Y___N

Do you receive extra help? ___Y___N

Do you prefer mail order? ___Y___N

Preferred Pharmacy________________________________

Current Plan _____________________________________

Preferred Hospital

____Mercy ____Cox Other ________________

Primary Physician__________________________________

Comments ____

Osborn & Associates
1200 E Woodhurst Ste V
Springfield MO 65804
800-647-0724 fax 417-877-1336