Cardinal Health™ MMS Solutions™ Specialty Pharmacy

New patient information

New patient **Address change**

Patient demographics

Facility name/ MMS account number:			
Patient name: Last:		First:	
Home address:			
City:	State:	ZIP:	
Home phone:		Cell/alt phone:	
DOB:	Sex: M F	Social Security No.:	
Allergies:			
Is patient vision impaired? Y N		Is patient hearing impaired? Y N	

Agent designation

Complete this section if the medication ordered is to be shipped to a facility.

I, ______________________ (Patient Name), a patient of ______________________ (Clinic name), located at ______________________ (Clinic address), appoint said dialysis facility to act as my agent to order and receive prescriptions on my behalf that have been prescribed by a licensed physician and dispensed by a licensed pharmacist, until I can take possession of them. As a patient at this facility, I have the right to obtain counseling from the pharmacist regarding any medication dispensed by this pharmacy. I can contact a pharmacist by telephone using the number found on the medication label.

Patient/Personal Representative name ______________________

Patient/Personal Representative signature ______________________

Responsible party in the dialysis clinic name ______________________

Responsible party signature ______________________

Date ______________________

*If patient is unable to sign this document, please provide a reason here

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La Vergne, TN 37086

866.716.5486
866.750.0823 (fax)

www.mmspharmacy.com

Please place original of this form in patient's medical record and fax a copy to MMS Solutions at **866.750.0823.**

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