Medication Refill Request Fax Form
Fax to 310-230-0284

Allow 2 Business Days for Processing

Complete **All** Fields in **Bold**

Your Last Name: ____________ **Your First Name:** ____________
Date of Birth: ____________ **Phone Number:** ____________
Physician: ____________ **FAX Number:** ____________
Date of Last Appt.: ______ **Date of Next Scheduled Appt.:** ____________
Email: ________________________

#1

Medication Name: ____________
% Strength, mg., etc.: ____________
Date of Last Refill: ____________
Directions for Use: ____________
Quantity Requested: ______
# of Refills Requested: ______

#2

Medication Name: ____________
% Strength, mg., etc.: ____________
Date of Last Refill: ____________
Directions for Use: ____________
Quantity Requested: ______
# of Refills Requested: ______

check one

- ☐ Pick up Prescription at PPMG Office
- ☐ Send Prescription via Mail
  Address: ____________
- ☐ Fax Prescription to Pharmacy
  Pharmacy Fax #: ____________
- ☐ Fax Prescription to Other Location
  Other Fax #: ____________

- ☐ Your Medication Refill Request Was Approved
- ☐ Your Medication Refill Request Was Not Approved
  Please Call Our Office and Schedule an Appointment to Review this Request

for office use only

N: ____________
D: ____________
#: ____________
R: ____________
Sig: ____________

N: ____________
D: ____________
#: ____________
R: ____________
Sig: ____________

- ☐ Gary Green, M.D.
- ☐ Richard Johnson, M.D.
- ☐ Julie Ma, M.D.
- ☐ Krysia McNicoll, M.D.

Notes to patient: ____________