

# URGENT FAX

**Directions For Use:**

Prescriber to complete prescription and fax **Prescriber signed** form to pharmacy.

**NOTE: The pharmacy cannot fill this order until they receive this signed document.**



(Pharmacy Routing Barcode)

## CONTROLLED SUBSTANCE PRESCRIPTION

**LTC Facility** – if you receive a verbal non-emergency order for any controlled substance, fax this form to the prescriber to be completed and signed by prescriber and then faxed to the dispensing pharmacy.

Regarding a prescription for this controlled substance \_\_\_\_\_  
Drug Name/Direction  
 for \_\_\_\_\_ at \_\_\_\_\_  
Patient Name Facility  
 \_\_\_\_\_  
Address Room #

This patient is:  LTCF Patient  Terminally Ill (Check a box - required by law for the partial fill of CII drugs)

**Prescriber (Full Name):** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_  AM  PM

**Prescriber Phone Number:** \_\_\_\_\_ **Prescriber Fax Number:** \_\_\_\_\_

**Prescriber Address:** \_\_\_\_\_

## PRESCRIPTION – Prescriber Must Complete This Section

Facility Name \_\_\_\_\_ Address \_\_\_\_\_  
 Resident Family Name \_\_\_\_\_ First Name \_\_\_\_\_ DOB \_\_\_\_\_ Admission # \_\_\_\_\_ Room # \_\_\_\_\_ Phone # \_\_\_\_\_

Date Ordered	Time Ordered	Date DC'd	MEDICATION	Order	Dose & Freq	Route	Directions For Use	INDICATION - Dx

**Quantity/Dispense:** \_\_\_\_\_  
(For CII up to a 60-day supply allowed)      **ALPHA** (ex. "Seven")      **NUMERIC** (ex. "7")  
**Number of refills:** \_\_\_\_\_ (only for CIII – V drugs)

**Prescriber Signature:** \_\_\_\_\_ **DEA Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Prescriber please fax signed form to:** \_\_\_\_\_ **Pharmacy Name Here** \_\_\_\_\_ **FAX Number Here** \_\_\_\_\_

**Nurse Receiving Order**  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

*The documents accompanying this fax transmission are **confidential**. Information contained in this fax transmission belongs to the facility sending the data and is legally privileged. The information accompanying this fax transmission is intended only for the use of the individual identified as "prescriber." The recipient of this information is prohibited from disclosing, copying, distributing or using this information except as permitted by current law governing privacy of information issues. Such information must be destroyed after its stated need has been fulfilled, unless otherwise prohibited by law. If you have received this fax transmission in error, please notify the "sender" immediately for return instructions.*



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Reorder From: **MED-PASS** 800-438-8884  
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