TRANSFER YOUR PRESCRIPTIONS TO CCM

NAME:_____

PHONE #:_____

DOB:_____

ARE YOU A PATIENT AT KINTEGRA FAMILY MEDICINE?

YES NO

PHARMACY NAME & PHONE NUMBER:

_____

LIST THE MEDICATIONS YOU WANT

TRANSFERRED INTO CCM TO BE FILLED HERE:

_____

_____

_____

_____

_____

*IF YOU WOULD LIKE US TO TRANSFER YOUR MEDICATION **OUT** OF CCM TO **ANOTHER PHARMACY**, PLEASE HAVE YOUR PHARMACY CONTACT US.

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TRANSFERIR SUS RECETAS A CCM

NOMBRE:_____

TELEFONO #:_____

FECHA DE NACIMIENTO:_____

ERES PACIENTE DE KINTEGRA FAMILY MEDICINE?

SI NO

FARMACIA & NUMERO DE TELEFONO:

_____

ENUMERE LOS MEDICAMENTOS QUE DESEA TRANSFERIR

Y COMPLETAR AQUI:

_____

_____

_____

_____

_____

*SI DESEA QUE LE TRANSFERIAMOS US MEDICAMENTO FUERA DE CCM A OTRA FARMACIA, POR FAVOR TENGA SUFARMACIA CONTACTENOS

TRANSFERIR SUS RECETAS A CCM

NOMBRE:_____

TELEFONO #:_____

FECHA DE NACIMIENTO:_____

ERES PACIENTE DE KINTEGRA FAMILY MEDICINE?

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Y COMPLETAR AQUI:

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