SWEETGRASS
PHARMACY & COMPOUNDING

SweetPak Rx Questionnaire

Patient Name: ____DOB: _____/_____/_______

Street Address: ____State: ________Zip: _____________

Phone No: _______________________Driver's License No./ID:___________________________State:________

Medicare A/B (Red, White, Blue Card) ID No.:____

Primary Insurance: __________RxBIN: ___________PCN: ___________RxGRP:_________ID#:________________

Secondary Insurance: ________RxBIN:____________PCN:___________RxGRP:_________ID#:_________________

Drug Allergies: ____

Family/Caretaker's Name: ______________________________________Phone No:________________________

Will patient's medications need to be delivered? __________(ID & Credit Card Info required for deliveries)

Special Delivery Instructions (gate codes, neighborhood, etc.): ____

Transferring Pharmacy: ________________________________Phone No: ______________________________

FULL list of medications currently taking:

Morning Medications	Time	Strength	Dose	Prescriber	Phone No.	Refills	Medication on Hand

Midday Medications	Time	Strength	Dose	Prescriber	Phone No.	Refills	Medication on Hand

Evening Medications	Time	Strength	Dose	Prescriber	Phone No.	Refills	Medication on Hand

Bedtime Medications	Time	Strength	Dose	Prescriber	Phone No.	Refills	Medication on Hand

Other Medications (OTC, creams, inhalers, etc.)	Time	Strength	Dose	Prescriber	Phone No.	Refills	Medication on Hand

Home Health Agency (if applicable):

Name of agency: ______________________________Phone No: ___________________

Contact Name: _______________________________Phone No: __________________

Payment Information:

Name on card: ____

Credit card number: ____

Card type: _______________Exp. Date: _________Sec. code: __________

How did you hear about Sweetgrass Pharmacy & Compounding?_______________

____

Sweetgrass Pharmacy & Compounding offers this complimentary medication packaging service to our patients in an effort to simplify the managing of their medication regimen, maintain their independence, and improve their quality of life. When transferring to this program, it's important to understand, we can only package the medications we dispense, and that not all medications may be covered initially, if they were filled recently at another pharmacy.

In addition, any prescriptions that are received after a patient's medications have been packed, will be dispensed in a bottle. We are unable to open packaging and make changes once the 30-day packaging is complete.

I am in agreement with these guidelines:

____

(signature)

SweetPak Rx Pharmacy Release Form

I ________________________________have enrolled in Sweetgrass

Pharmacy's SweetPak Rx Program as of _______________. Please update them
(date)

as my pharmacy of choice in my chart. Please send any new prescriptions or prescription

renewals to Sweetgrass Pharmacy. Please make them aware of any dose changes or medications

that are being discontinued.

Phone: 843/654-4013 Fax: 843/654-4014

____
(Signature)