



423d Medical Squadron Medication Request Information Form

This REQUEST FORM is for you to request renewals on medications that you have been taking on a daily basis or for medications you have taken for a long period of time.

Our goal is to provide you with the highest level of safe patient care.

REQUESTS that MAY be **declined** by your Primary Care Manager (PCM) include; but are not limited to:

New prescriptions

Medication for short term use or as needed (30 days or less)

Narcotic pain medications

Medications that were prescribed by a provider outside of this clinic

Medications you are requesting without having had a follow-up appointment or appropriate lab tests

Anti-anxiety medications

Medications you are requesting and you have never had a medical appointment in this clinic for your health condition

Your PCM will approve or decline your medication request.

This form must be reviewed by the nurse or medical technician before you turn it in. You will be advised to schedule an appointment with your PCM for any medication that may be declined. Your request will be processed and ready for pick up at the Main Pharmacy by 1500 hours. **Please note: if your request is turned in after 1000 it will be available the following duty day at 1500 hours.**

Please call DSN 268-4503; Commercial 01480-84-4503 to schedule an appointment or go to www.tricareonline.com to book your own appointment.

Please ensure you have scheduled a follow up appointment with your PCM prior to utilizing the pharmacy renewal or refill service.

423d Medical Squadron Request Form
(Please Print)

Your Name: _____ **SSN:** _____ **Birth Date:** _____

Today's Date: _____ **Time** _____

Sponsor's SSN: _____ **Primary Provider: BOHL or DISEATI**

Contact number: _____ **OR** _____

Can we leave you a voicemail on this number? **Yes or No**

Do you have a medical appointment in the next 30 days? **Yes or No**

If YES: Date: _____

List medication(s) you are requesting:

Please provide the medication name, dosage and how often you take the medication.

Are you having any side effects from this medication(s) Yes or No?

If Yes **call for the nurse to triage your condition/**seek medical advice...

Comments: medication ordered _____ declined _____ needs appt _____

Patient notified by phone: yes or no

Patient instructions/notes:

Request processed: (stamp, sign and date) _____

423d Medical Squadron Appointments: 01480 84 4503 DSN: 268-4503