CENTRAL PHARMACY PATIENT MEDICATION INFORMATION

Instructions:

1. Please send a completed Patient Medication Information sheet to Central Pharmacy for:
   a. Each new patient.
   b. Any update on existing patient (i.e. change in clinical information, patient information).

2. Remember to:
   a. Type or print legibly in ink.
   b. If new patient, send with new prescription.
   c. This form is required for Central Pharmacy program statue per Board.

3. Fax to: (614) 752-0151 or Mail to: Central Pharmacy Outpatient
   2150 West Broad Street
   Columbus, Ohio 43223-1200
   (614) 752-0150

☐ **New Patient** ☐ **Existing Patient**

Printed Name of Person Completing Form	Date Information was Taken

CLINIC INFORMATION	
Clinic Name	
Clinic Number	
Clinic Address	

PATIENT INFORMATION			
Patient Name	First	M.I.	Last
Patient Numbers	Patient Number	MACSIS UCI Number	
Patient Date of Birth (mm/dd/yyyy)			
Patient Address			
Patient Telephone Number			
Patient Gender (circle one)	Male Female		
Patient Race (circle one)	Caucasian African-American Asian American Indian Other: please specify		

CLINICAL INFORMATION	
MENTAL HEALTH DIAGNOSIS – ICD-9 code	
CHRONIC DISEASE STATE(S)-DX ICD-9 code	
Drug Allergies (to indicate no known drug allergies, please circle)	No Known Allergies
Adverse Drug Reactions or Idiosyncrasies	
Other Medications patient is taking (include herbal and over-the-counter medications)	

Confidential Information: Pursuant to State law, the information that is being transmitted is confidential and it must not be reviewed by unauthorized parties. It must be immediately given to the person listed as the recipient. If this information has been transmitted to you in error, please immediately notify the sender.