REQUEST FOR PATIENT CONSULT

Patient Name: _____

Phone Number: _____

DOB: _____

Referring Provider: _____

Medication list attached?

- Yes
- No

Please remind your patient we will be contacting them to schedule a FREE in-store consult on their medications.

If you would like a copy of your patient's completed consult, please provide your name and fax number.

Name:_____

Fax:_____

Please fax this form to the GenScripts Pharmacy location most convenient for your patient.

Tulsa	Broken Arrow	Owasso	South Tulsa/Bixby
41st & Hudson	81st & Garnett	96th & Garnett	109th & Memorial
Fax: 918-828-9778	Fax: 918-615-3372	Fax: 918-274-9698	Fax: 918-921-7176