TRANSFER REQUEST FORM



TEL: 509.773.7117



FAX: 509.772.2737

Transfer Request Form

Transfer Rx request for patient:	NAME
	DATE OF BIRTH
If you fill your prescriptions out of the	area, would you like to transfer? \Box Yes \Box No
Transfer Rx(s)	Notes:
	-
	-
	-
	-
	_ Thank You,
	D

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