KVH PHARMACY

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? ☐ Yes ☐ No

Transfer Rx(s)

_____

_____

_____

_____

_____

_____

_____

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_____

Notes:

Thank You,

_____ ,RPh