

Rx (Cross out unused blanks below)	Strength	Amount	Directions	Refill	
1.					
2.					
3.					
a. Full Name of Patient (AGE if under 12) (Use Plastic Card or PRINT)			Signature of Prescriber		PHARMACY USE ONLY
			Prescriber Identification (Name, SSN or BNDD, Grade Degree, Service and Facility)		
b. SSN of Sponsor:			UCA Code:		
c. Patient's Address (Mandatory for Controlled Substances)			d. Work/Home Telephone (For emergency only)	Date	