

Gahanna Family Practice, Inc.
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(614) 428-8200 ~ fax (614) 428-9700
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Refill Request Fax Form

Date: ____ / ____ / ____

Prescription Type:

- Pick up at office: pharmacy information **not required**
- Call in to pharmacy: pharmacy information **required**

Patient Information

All fields are required.

Patient's Name: _____

Patient's Date of Birth: ____ / ____ / ____

Patient's Daytime Phone: (____) _____

Medication Information

All fields in bold type are required.

Name of Medication: _____

Strength of Medication: _____

Quantity Requested: _____

Prescribing Doctor: _____

Dosage Directions:

Pharmacy Information

Both fields required if prescription is to be called into a pharmacy.

Pharmacy Name: _____

Pharmacy Phone Number: (____) _____

Additional Comments or Instructions

Fax this form to (614) 428-9700.