REQUEST FOR PATIENT CONSULT

Patient Name: ____________________________________

Phone Number: _____________________

DOB: _______________

Referring Provider: ________________________

Med list attached?

- Yes
- No

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

If you would like to know if your patient has completed the consult, please provide your name and email.

Name:____________________________

Email:_____________________________________

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

Tulsa 41st & Hudson Fax: 918-828-9778	Broken Arrow 81st & Garnett Fax: 918-615-3372	Owasso 96th & Garnett 918-274-9698	South Tulsa/Bixby 109th & Memorial Fax: 918-921-7176	Glenpool/Jenks 121st – W of Hwy 75 Fax: 918-552-1030