Prescription Transfer Form

If possible, have your provider send a new prescription directly to Quadrangle Pharmacy, located inside Habif Health and Wellness Center. This will allow you to still have any previously existing refills on file at your home pharmacy for use during breaks. It can be prescribed electronically, by fax or phone, or written and brought to the pharmacy. If your provider refuses to do this and you would like to have active prescriptions transferred from your home pharmacy, please fill in the spaces below. *Please present a copy of your prescription insurance card to the pharmacy prior to filling any prescriptions*. This form can be e-mailed to quadpharmacy@wustl.edu or dropped off at the pharmacy. Call Quadrangle Pharmacy at 314-935-6662 if you have any questions.

*New York Residents: New York state law limits the ability to transfer prescription refills. Please have your provider call or fax us new prescriptions or write them for you to bring to the pharmacy instead of requesting a transfer.*

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Include ALL items that you will need transferred for the upcoming semester.**

Pharmacy Name, City, and State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Rx #****(Required)** | **Drug Name and Strength** | **# Refills Remaining****(Required)** | **Need within** **a week?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Pharmacy Name, City, and State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Rx #****(Required)** | **Drug Name and Strength** | **# Refills Remaining****(Required)** | **Need within** **a week?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |