Omnicare Pharmacy Fax Cover Page *Check Appropriate Box(s)*

From: Community Name: _____Date:_____

Regarding Resident Name: _____

Resident DOB: _____ Pages: (including cover) _____

☐ **New Resident**: Required paperwork listed below and sent with this fax.

_____ Resident Pharmacy Agreement NOTE: The following information is needed on every resident
_____ Insurance card front and back Resident Name, Apt Number,
_____ Prescriptions M.D. Full Name and Phone Number
_____ Face Sheet Allergies, Move in date, Diagnosis

☐ **New Prescription(s)**: meds needed – **FILL AND SEND ALL MEDS** included with this fax:

☐ Send with next scheduled delivery

☐ Send STAT/ ASAP/Special delivery (Please call pharmacy to confirm STAT)

Community spoke with _____at pharmacy and verified fillable script.
Shipment is expected at _____on_____.

☐ **New Prescription(s): DO NOT SEND ANY MEDS** at this time:

Please Profile the order – community will request when needed.

☐ **New Prescription(s): Only fill and Send the following orders** and update the rest on the Residents' profile

Send: _____need by: _____ Send: _____need by: _____
Send: _____need by: _____ Send: _____need by: _____

☐ **Discontinued medication:** Medication(s): _____ _____

☐ **Resident out of community to Hospital/Skilled or Rehab.**: Date _____

☐ **Resident returned from Hospital/Skilled or Rehab.**: Date _____

☐ **Resident moved from community on**: Date _____

☐ **Resident is deceased:** Date _____

Form Completed by: _____ Please call _____ for clarifications.
Signature