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

From: Community	Name:		Date:		
Regarding Reside	nt Name:				
Resident DOB:			Pages: (including	cover)	
			low and sent with this fax.	,	
Resident Pha Insurance car Prescriptions	rmacy Agreemen rd front and back M.D. Full Name a	t NOTE: The follo Resident Name, A and Phone Numb	wing information is needed on Apt Number,	every resident	
Face Sheet A	llergies, Move in	date, Diagnosis			
□ New Prescri	ption(s): med	s needed — <b>FILL</b>	AND SEND ALL MEDS	included with this fax:	
☐ Send with next se	cheduled delivery	,			
☐ Send STAT/ ASAF	/Special delivery	(Please call pharr	nacy to confirm STAT)		
Community spoke v	Community spoke withat pharmacy and verified fillable script.				
Shipment is expected	ed at	on	·		
Please Profile the or	rder – community	will request whe			
Residents' profile	ption(s): On	iy fili and Se	na the following orde	<b>rs</b> and update the rest on the	
•	need by:	Send:	need by:		
Send:	need by:	Send:	need by:		
<ul><li>□ Discontinue</li></ul>	d medicatio	<b>n:</b> Medication(s)	·		
☐ Resident ou	t of commu	nity to Hospi	tal/Skilled or Rehab.:	Date	
□ Resident ret	turned from	Hospital/Ski	lled or Rehab.: Date		
			 <b>1:</b> Date		
□ Resident is (					
	_		<del></del>		
Form Completed by	:		Please call	for clarifications.	
	Signature				

## Confidential

This information transmitted is intended only for the person or entity to which it is addressed and may contain confidential and /or privileged material, the disclosure of which is governed by applicable law. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon, this information by persons other than the intended recipient is prohibited. If you have received this in error, please contact the sender and destroy the material contained in this message. Last Update: 2.1.19