

MEDICATION REFILL REQUEST

Patient's printed name:

Date:

Sponsor's social security number:

Please use the sample label illustrated below to complete this form. The same form may be used for the entire family.



DUNHAM U.S. ARMY HEALTH CLINIC PHARMACY
CARLISLE BARRACKS, MD 17013 PH. 245-4509
KEEP OUT OF THE REACH OF CHILDREN



942764

JONES, JOHN P

SMITH, JOHN

TAKE ONE TABLET EVERY 4 HOURS

Note: Prescription expires six months from this date.

ASPIRIN 325MG TABLET

REFILLS 5
(03/17/90)

QTY: 30 TAB
MLU (04/17/90)

PRESCRIPTION NO.	MEDICATION	QUANTITY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

This form must accompany all prescription containers.

Checked/filled by:

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