

Pharmacist Recovery Network 3501 W Elder St., Ste. 201 Boise, ID 83705

## YEARLY UPDATED PRESCRIPTION DRUG LIST

Office: (208) 323-9555

Fax: (208) 323~9222

This form is to be filled out by any practitioner who is prescribing you medications.

The Completed form must be mailed/faxed by the practitioner's office.

(Printed Participant's Name)

scription Date	Type of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication	
his/her  And/or  I have t	drug(s) of choice is/are:	ient is involved in a monitoring plant is involved in a monitoring plant is involved in a monitoring plant is of:	program. I understand that	
He/SHe I	nas a mentai neattii diagno	SIS 01.		
Practitioner's Name (Please print)		Practitioner's	Practitioner's Signature	
Practitioner's Phone Number		Date		
Practiti	oner's Address			
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