UTCVM VETERINARY MEDICAL CENTER

PHARMACY Rx REQUEST
FOR REFERRING VETERINARIANS

2407 River Drive, Knoxville TN 37996
UTCVM Pharmacy Phone: (865) 974-5670 Fax: (865) 974-8533

FAX COMPLETED FORM TO 865-974-8533

Prescriptions are usually available within 3 hours of faxed receipt.
Orders received before 4:00 pm will be filled the same day.
**Please understand that some compounding preparations may take up to 24 hours to fill.*

Practice Information

Practice:	
Veterinarian:	
Street Address:	
City:	
State:	Zip:
Phone:	
Fax:	
Email:	

Client/Patient Information

Owner:			
Street Address:			
City:			
State:	Zip:		
Phone:			
Email:			
Patient Name:			
Breed:	Color:		
Species: Canine Feline Equine Bovine Other:__________	Sex: Female Male	Neutered/Spayed Intact	
	Weight:	lbs Kg	DOB:

Delivery or Pick Up? (Check one)

For you and your client's convenience, our pharmacy offers various delivery options.

- Owner will pick-up at UTCVM Pharmacy.
- Prescription to be mailed to the Owner's address above. (A flat fee of $15 will be applied for shipping. The order will be delivered via FedEx.)
- Prescription to be mailed to practice. (A flat fee of $15 will be applied for shipping. The order will be delivered via FedEx.)
- Practice will pick up at UTCVM Pharmacy.
- Courier Service delivery is available for practices within a 45-mile radius of UTCVM. (Standard courier fee applies)

Payment options (Check one)

- MEDICATION AND SUPPLIES FOR PRACTICE USE ONLY (office-use pricing)
- Owner will pay the UTCVM standard pharmacy price

Acceptable forms of payment include: Cash, check or credit card (Visa, Master Card, Discover and Care Credit).

For a list of available medications and compounding preparations, please visit: vetmed.tennessee.edu/vmc/HospitalOperations/Pharmacy

SPECIAL INSTRUCTIONS

I would like directions to be placed on bottle: (check one) YES NO

REQUEST/INSTRUCTIONS Limit 3 RX's Per Form

Medication:

SIG:

Qty:____________________

Refill ______Times No Refill

Medication:

SIG:

Qty:____________________

Refill ______Times No Refill

Medication:

SIG:

Qty:____________________

Refill ______Times No Refill

DVM

Clinician's Signature Date

DEA NO.____

CHARGES

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