

Medication Pickup Plan

Patient Name:

Date of Birth:

We're happy to have all of your medications ready for pickup on the same day!
We need your help to get started. Once you complete this schedule, your medications will all be ready on the same day.

Here is your medication schedule:

Rx number	Medication name	# Pills	# Days	Pickup date

Then, your regular pickup day will be:



Yes, I want one pickup!

I'm going to save a trip to the pharmacy by having all of my medications ready on the same day.

I agree to:

- Pick up my medications on my designated pickup date
- Tell my pharmacist about any doctor appointments, hospital visits, or health changes that might affect my medications
- Let my pharmacist request refills from my doctor when my prescription runs out

My pharmacist might contact me by:

- Call (home phone number: _____)
- Text message (cell phone number: _____)
- Email (email address: _____)

Patient Name (Print)

Pharmacist Name (Print)

Patient Signature

Date

Pharmacist Signature

Date