Prescription Transfer

From: (Name of your Pharmacy):	Date:
Pharmacist Name:	To: Bayview Pharmacy 3844 Post Road Warwick, RI 02886
Phone Number (if we need to reach you):	Phone: 401-284-4505 **Fax to: 401-284-4506**

*If prescriptions needs to be rushed, please check off: URGENT [ ]

In the box below, please include as much of the patient's information as possible as it will help us process the order.

Patient Name: Date of Birth: Phone Number: Address: Insurance Information: Allergies: Other medications being taken:	Prescription information: Rx# Date of issuance of original Rx: Original Fill Date: Original # of Refills: Refills remaining: Drug: Quantity Prescribed: SIG: Prescriber Name: Prescriber Phone #: Address: DEA #:

*If you have your own Transfer form which has all of the necessary information indicated above, please feel free to fax that in place of our form.