

PRESCRIPTION INFORMATION

INSTRUCTIONS: This form is to be used by all RPP Participants who require prescription medications. The completed form MUST be mailed by the healthcare provider only, to the address below or faxed to (803) 896-5710. If you have any questions, call (803) 896-5700 or toll free 1-877-349-2094. Please list all medications prescribed for your patient in the last year.

(Please Print) _____
PARTICIPANT NAME
Recovery Specialist

DATE OF PRESCRIPTION	TYPE OF MEDICATION	QUANTITY & DOSAGE PRESCRIBED/NUMBER OF REFILLS	REASON FOR MEDICATION

I have been informed that this patient is being monitored by RPP for Health professionals for (check one) Chemical Dependency Dual Diagnosis
 Healthcare Provider Information:

Name: _____ Telephone: _____

Facility: _____

Address: _____

 Healthcare Providers Signature

 Date