



# PRESCRIPTION FORM

Please fax completed form to **501-214-1451** or call **501-214-1444**

7321 Cantrell Road • Little Rock, AR 72207 • www.lrockrx.com

PATIENT INFORMATION		PLEASE FAX WITH PATIENT DEMOGRAPHIC SHEET	
Name	Date of birth	Sex	
Email	Phone #	Mobile Phone #	
Street Address	City	State	Zip
Driver's License Number	State of Issue	Social Security #	
Safety Caps on bottles <input type="checkbox"/> Yes <input type="checkbox"/> No (easy-off caps preferred)	Allergies		

MEDICATION / TYPE	STRENGTH	QUANTITY	SIG	REFILLS
Additional Directions				

PRESCRIBER INFORMATION				
Prescriber Name (Please print)		Signature	Date	Office Contact
NPI#	DEA#	Phone	Fax	
Street Address		City	State	Zip

Confidentiality Notice: This fax is intended for the sole use of the individual and entity to which it is addressed, and may contain information that is proprietary, confidential, privileged and prohibited from being disclosed under applicable law. If you are not the intended addressee, nor authorized to receive for the intended addressee, you are hereby notified that you may not use, copy, disclose or distribute to anyone facsimile or information contained in the fax. If you received this by mistake, please contact LRockRX at 501-214-1451.