Health Spectrum Pharmacy Services **Refill Transfer Form**

Please submit completed form to the pharmacy when you have 7-10 days of medication remaining.

You can drop off the form at any of the pharmacies or fax to the number below:

Lehigh Valley Hospital–Cedar Crest
Fax: 610-402-8800
Lehigh Valley Hospital–Muhlenberg
Fax: 484-884-2969
Lehigh Valley Hospital–17th Street
Fax: 610-969-2784
Lehigh Valley Hospital–Pocono
Fax: 570-476-3645

Patient Name	
Date of Birth	Daytime Phone Number
Street Address	City, State, Zip Code
Current Pharmacy Name	Current Pharmacy Phone Number

1	Prescription Number:	Medication Name:	Strength:_____
	Prescriber:	Prescriber's Phone Number:	Supply: 30 60 90
2	Prescription Number:	Medication Name:	Strength:_____
	Prescriber:	Prescriber's Phone Number:	Supply: 30 60 90
3	Prescription Number:	Medication Name:	Strength:_____
	Prescriber:	Prescriber's Phone Number:	Supply: 30 60 90
4	Prescription Number:	Medication Name:	Strength:_____
	Prescriber:	Prescriber's Phone Number:	Supply: 30 60 90
5	Prescription Number:	Medication Name:	Strength:_____
	Prescriber:	Prescriber's Phone Number:	Supply: 30 60 90

Are you currently enrolled in our Convenience Shipping program? Yes No

If 'no' and are interested in having prescription refills mailed to your home, please sign below. By signing, you are agreeing for the pharmacy to contact you at the number provided to complete the enrollment process.

Signature:_____ Date:_____