Prescription Hope

YOUR MEDICATION ADVOCATES

PrescriptionHope.com

Change or Substitute a Medication

Date: _____

Name: _____
First M.I. Last

Date of Birth: _____/_____/_____
Month Day Year

Address: _____
Street City State Zip

Phone Number: _____ Email: _____

My doctor has switched my medication *(use additional sheet of paper if needed).*

Please cancel this medication: _____
Name

_____
Strength Qty Frequency (ex. Twice Daily)

and replace it with this medication: _____
Name

_____
Strength Qty Frequency (ex. Twice Daily)

Prescribing Doctor Information for New Medication

_____
Name

_____
Street Address/Suite Number City State Zip

_____
Phone Number

_____
Fax Number

Patient Signature: _____