



## Autism Center

### PLEASE COMPLETE THE FOLLOWING INFORMATION

A list of All Medications

A list of All Allergies to Medicine

Your Pharmacy Name, Address and Fax Number

Primary Care Physician Name, Address, Phone and Fax

Medications \* If you have more medications, please list on the back or provide us with a copy


Allergies to Medicine


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Primary Care Physician Name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_