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

Primary Care Physician Name: _____
Physician Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

Pharmacy Name: _____Pharmacy Fax: _____
Pharmacy Address: _____