Community Care Rx

***TO BE USED IN THE EVENT ACCESS TO WEB-CONNECT IS NOT AVAILABLE**

Medication Discontinuation Form

Facility Name: _____

Nurse/ Medical Coordinator: _____

Patient Name: _____Date of Birth:_____

Rx Number	Drug Name	Start Date	D/C Date

131 Sunnyside Blvd, Suite 100, Plainview, NY 11803
Tel: 516-418-8058 * Fax No: 347-561-3835

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