Corner Drugs Simple Pack Intake Form

Name _____ □Existing Patient □New Patient

Phone _____Address _____

Date of Birth ___/___/_____ Sex □Male □Female

Social Security Number _____(to look up insurance info if you don't have your insurance card)

Do you want to pick up have your monthly Corner Packs Delivered? □ Pick up □ Delivery

Drug Allergies _____

_____

Known Health Conditions _____

_____

Please list a caregiver or other person we may need to contact:

Name _____Phone # _____Relationship_____

Do you have a date in mind that would be your Day-1 start date for the Corner Pack? _____

If no, we can help determine the best day for you that will work with your schedule.

Other information

In the past 12 months have you had a hospital stay longer than over night? □Yes □No

Are you being treated for any ongoing illness like cancer, chemotherapy, a recent heart patient, new disease diagnosis? □ NO □ YES If yes, please discuss with the pharmacist.

Who is your regular primary care medical provider (your doctor)? _____

Do you see other doctors or medical providers? If so please list:

Name _____ City/St _____Phone _____

Name _____ City/St _____Phone _____

Name _____ City/St _____Phone _____

Name _____ City/St _____Phone _____

If you are a new patient for us we will need to transfer ALL prescriptions from your current pharmacy or pharmacies. What is the name of the pharmacy or pharmacies that we need to contact?

Pharmacy Name_____ Ph# _____

Pharmacy Name_____ Ph# _____

Pharmacy Name_____ Ph# _____

Child Safety Waiver: Corner Simple Packs are not child resistant and should be kept out reach of children (and animals) at all times. By accepting the Simple Pack Box, you agree to waive the child resistant safety requirements for prescription drug packaging for new prescriptions and refills.

Signed _____ Date _____

Your name _____

Please provide a list of your prescription medications (add another page if needed)

Medication Name	Strength	How often do you take?	What time of the day do you take?	Other information

List of OTC medications, vitamins and supplements (add another page if needed)

Supplement/Vitamin/ OTC Name	Strength	How often do you take?	What time of the day do you take?	Other information

Your Name _____

To make Corner Packs FREE please understand the following:

Your responsibilities:

- **Communication is very important! Take ownership in your health!**
- **You must keep us informed** of any medication changes. **If your prescriber changes, stops or adds anything tell us and have them contact us.** We need to know for our records and your health. If we don't know we can't do our job as a pharmacist and a pharmacy.
- **Let us know** if any of your medication has, **will or may be changing** 7 days **BEFORE** your Corner Packs are due when possible. If we run your packs and your medication has changed and **we were not notified** there may **be a charge** to repack your medication.
- **Let us know** if you are in the hospital, rehabilitation center, or for any other reason you **skip your medication**.
- **Let your medical prescribers** know you are having your medication packaged (Corner Packs). **Tell them Corner Drugs may contact them** for early refills so we can be prepared to package your medications when due.
- **If we don't hear from your prescriber on refill authorizations** we will ask that you call them. We will have made several attempts to get refill authorizations before we ask you to call. If we don't hear from them and get refill authorization the medication will not be in the Corner Pack.

What Corner Drugs will do for you:

- We will fill and package all your routine medications for a 30-day supply
- If needed, contact your medical prescribers at least 7 days in advance for refills, if **they do not respond** in a timely manner, that medication **may not** be packaged.
- We **will not package** "PRN, as needed, or pain medications and other medications that are not appropriate for dose packaging. These will still be in traditional prescription bottles.

Date _____

Pharmacist _____ Patient _____

GIVE THIS PAGE TO PATIENT (MAKE COPY)

Pharmacy ONLY

Pharmacy Notes for _____ Date _____

Start Date is determined to be _____

Miscellaneous details _____

_____

_____

_____

_____

_____

□ Delivery or □ Pick Up

Best phone number to call:

Name _____ Relationship _____ Phone# _____

Any barriers that may cause issues? _____

_____

_____