



Rex Pharmacy- RexPaks Enrollment Form

Patient Information

Full Name: _____ Birthdate: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email: _____

Physician: _____ Other Contact Name: _____ Other Contact Phone: _____

Does patient receive Home Health Care? YES NO If yes, contact info? _____

Do we need to transfer prescriptions? YES NO If yes, from where? _____

Medication List

Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____
Medication: _____	Instructions: _____	Times: _____

Pick-Up/Delivery Details

Delivery type? WILL CALL DELIVERY MAIL Anticipated Start Date: _____

Special Instructions: _____

Disclaimer and Signature

By enrolling in RexPaks I understand and accept Non-Child Resistant Packaging as defined by the Poison Prevention Act. Please keep all medications out of the reach of children.

Patient or Caregiver: _____ Date: _____

