

# MAIL-IN REFILL PRESCRIPTION REQUEST

(Privacy Act Statement is Available at Prescription Counter)

To request a refill of your prescription, fill out both sections of this form. To mail, fold this card and secure with tape. Mail no sooner than 20 days, but no later than 10 days before your medication runs out. We will hold the filled prescription up to 7 days after the Pick-up Date. Be sure to bring the patient's US Armed Forces ID Card (DA Form 2A) to the Outpatient Pharmacy pick-up window when picking up your refills.

If you have any questions, please call the Pharmacy at  
(804) 734-9141

I WILL PICK-UP THIS REFILL ON \_\_\_\_\_

NAME (please print): \_\_\_\_\_

FMP/SSN: \_\_\_\_\_

Patient's Status/Sponsor's SSN

PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_

FOLD

.....

1. PRESCRIPTION NO: \_\_\_\_\_ DRUG: \_\_\_\_\_

2. PRESCRIPTION NO: \_\_\_\_\_ DRUG: \_\_\_\_\_

3. PRESCRIPTION NO: \_\_\_\_\_ DRUG: \_\_\_\_\_

4. PRESCRIPTION NO: \_\_\_\_\_ DRUG: \_\_\_\_\_

5. PRESCRIPTION NO: \_\_\_\_\_ DRUG: \_\_\_\_\_

6. PRESCRIPTION NO: \_\_\_\_\_ DRUG: \_\_\_\_\_

7. PRESCRIPTION NO: \_\_\_\_\_ DRUG: \_\_\_\_\_

8. PRESCRIPTION NO: \_\_\_\_\_ DRUG: \_\_\_\_\_

FOR OFFICIAL USE ONLY

Filled By:

Checked By:

MEDDAC FORM 581

REV 15 APRIL 1996

Previous editions are obsolete.

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FROM

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



CDR USAMEDDAC  
ATTN MCXO RXS  
700 24TH STREET  
FORT LEE VA 23801-1716

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**The Pharmacy Service, Kenner Army Community Hospital is dedicated to providing high quality and efficient prescription services. In this regard, we have initiated a mail-in refill prescription service for the purpose of reducing refill prescription waiting time at the Outpatient Pharmacy.**

**AUTHORITY.** Army Regulation 340-21  
**MANDATORY OF VOLUNTARY DISCLOSURE .**  
Voluntary  
**PRINCIPAL PURPOSE FOR COLLECTING THE INFORMATION .**  
The information collected will be used to identify and retrieve computer records.  
**EFFECTS OF NOT PROVIDING THE INFORMATION .**  
There may be a delay in refilling the prescription.