

**INTEGRATED PHARMACY SERVICES**  
**PO BOX 407**  
**BOYSTOWN, NE 68010**  
**1-800-633-7928 OR 1-402-697-8622 (Nebraska)**

**HOME DELIVERY PRESCRIPTION ORDER FORM**

**ORDERING INSTRUCTIONS:** Enclose this order form with each order and if possible, ENCLOSE YOUR DOCTOR'S ORIGINAL PRESCRIPTION(S) and mail to the address listed above. Please call us at the above phone number if you have any questions regarding your medications, or would like to receive additional information from us.

PLEASE FILL IN THIS FORM COMPELTELY. (PLEASE PRINT CLEARLY.)

**INSURED'S INFORMATION**

EMPLOYER/COMPANY NAME \_\_\_\_\_ SSN \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**DOCTOR INFORMATION**

DOCTOR'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

DOCTOR'S ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**PATIENT INFORMATION**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

RELATIONSHIP TO INSURED: SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ DEPENDENT \_\_\_\_\_

CHILD SAFETY CAPS: PLEASE CIRCLE YES or NO

CHRONICAL MEDICAL CONDITIONS \_\_\_\_\_

CURRENT MEDICATIONS (Include ALL Drugs) \_\_\_\_\_

KNOWN DRUG ALLERGIES \_\_\_\_\_

**PLEASE ATTACH ADDITIONAL INFORMATION IF NECESSARY**

\_\_\_\_\_  
INSURED'S SIGNATURE

\_\_\_\_\_  
DATE SIGNED

When ordering "maintenance" medications, ask your doctor to prescribe in volume quantity. This reduces the number of times you need to order. Generics will be used when legally permissible and when not prohibited by your physician. A REGISTERED PHARMACIST WILL ALWAYS BE REDILY AVAILABLE TO PROVIDE CONFIDENTIAL CONSULTATION.