Proprium
PHARMACY

535 Independence Parkway, Suite 400
Chesapeake, VA 23320
Phone: 757-553-3568
Fax: 757-819-7827

PRESCRIPTION DELIVERY LOG

Instructions: Patient and Prescriber must sign below in the appropriate areas.
Completed form must be returned to Proprium Pharmacy within 28 days of administration/delivery date

*** FULFILLMENT STAFF *** PLACE DELIVERY LOG RX LABEL HERE	**ORDER NUMBER:**
	DISPENSE DATE:
	PHARMACIST SIGNATURE:

For PRESCRIBER/DESIGNATED AGENT Use Only

I certify I am the prescriber, or designated agent thereof, and the medication(s) dispensed by Proprium Pharmacy is/are in accordance with the prescription/physician order. This order is complete and accurate and the medication(s) has/have been stored and handled appropriately to ensure the stability, integrity, and security of the contents. I understand if we are unable to administer or deliver this order to the patient within 28 days of the dispense date, I will notify the pharmacy to develop an appropriate action plan or destroy the medication. I will document the action plan/destruction in the patient acknowledgement section below and return the form as indicated. No credit will be provided for unused or destroyed medications.

Prescriber/Designated Agent Printed Name: _____

Prescriber/Designated Agent Signature: _____

Clinic Name: _____ **Date:** _____

PATIENT Acknowledgment of Receipt of Prescription

I acknowledge that, at my request, my prescription order (dispensed by Proprium Pharmacy) was delivered directly to the alternate delivery site specified above. I acknowledge receipt of my entire prescription order, including any necessary supplies.

Patient Signature: _____ **Date:** _____

Return Signed Form to Proprium Pharmacy Within 28 Days of Dispense Date

FOR PROPRIUM USE ONLY	
Date Received Back:	
Log Scanned In By:	

Delivery Log

V: 100217

Proprium
PHARMACY

535 Independence Parkway, Suite 400
Chesapeake, VA 23320
Phone: 757-553-3568
Fax: 757-819-7827

PRESCRIPTION DELIVERY LOG

Instructions: Patient and Prescriber must sign below in the appropriate areas.
Completed form must be returned to Proprium Pharmacy within 21 days of administration/delivery date

*** FULFILLMENT STAFF *** PLACE DELIVERY LOG RX LABEL HERE	**ORDER NUMBER:**
	DISPENSE DATE:
	PHARMACIST SIGNATURE:

For PRESCRIBER/DESIGNATED AGENT Use Only

I certify I am the prescriber, or designated agent thereof, and the medication(s) dispensed by Proprium Pharmacy is/are in accordance with the prescription/physician order. This order is complete and accurate and the medication(s) has/have been stored and handled appropriately to ensure the stability, integrity, and security of the contents. I understand if we are unable to administer or deliver this order to the patient within 21 days of the dispense date, I will notify the pharmacy to develop an appropriate action plan or destroy the medication. I will document the action plan/destruction in the patient acknowledgement section below and return the form as indicated. No credit will be provided for unused or destroyed medications.

Prescriber/Designated Agent Printed Name: _____

Prescriber/Designated Agent Signature: _____

Clinic Name: _____ **Date:** _____

PATIENT Acknowledgment of Receipt of Prescription

I acknowledge that, at my request, my prescription order (dispensed by Proprium Pharmacy) was delivered directly to the alternate delivery site specified above. I acknowledge receipt of my entire prescription order, including any necessary supplies.

Patient Signature: _____ **Date:** _____

Return Signed Form to Proprium Pharmacy Within 21 Days of Dispense Date

FOR PROPRIUM USE ONLY	
Date Received Back:	
Log Scanned In By:	

Delivery Log

V: 122916

Proprium
PHARMACY

535 Independence Parkway, Suite 400
Chesapeake, VA 23320
Phone: 757-553-3568
Fax: 757-819-7827

PRESCRIPTION DELIVERY LOG

Instructions: Patient and Prescriber must sign below in the appropriate areas.
Completed form must be returned to Proprium Pharmacy within 21 days of administration/delivery date

*** FULFILLMENT STAFF *** PLACE DELIVERY LOG RX LABEL HERE	**ORDER NUMBER:**
	DISPENSE DATE:
	PHARMACIST SIGNATURE:

For PRESCRIBER/DESIGNATED AGENT Use Only

I certify I am the prescriber, or designated agent thereof, and the medication(s) dispensed by Proprium Pharmacy is/are in accordance with the prescription/physician order. This order is complete and accurate and the medication(s) has/have been stored and handled appropriately to ensure the stability, integrity, and security of the contents. I understand if we are unable to administer or deliver this order to the patient within 21 days of the dispense date, I will indicate this in the patient acknowledgement section below, properly destroy the medication, and return the signed form. No credit will be provided for unused, destroyed medications.

Prescriber/Designated Agent Printed Name: _____

Prescriber/Designated Agent Signature: _____

Clinic Name: _____ **Date:** _____

PATIENT Acknowledgment of Receipt of Prescription

I acknowledge that, at my request, my prescription order (dispensed by Proprium Pharmacy) was delivered directly to the alternate delivery site specified above. I acknowledge receipt of my entire prescription order, including any necessary supplies.

Patient Signature: _____ **Date:** _____

Return Signed Form to Proprium Pharmacy within 21 days of Dispense Date

FOR PROPRIUM USE ONLY
Date Received Back: _____
Log Scanned In By: _____

Delivery Log

V: 110716