SCANA Pharmacy
Incoming Prescription Transfer Information

Patient's Name _____ Date of Birth: _____

Patient Phone #: _____ Patient E-mail: _____

Pharmacy Name: _____ Date Sent: _____

Pharmacy Address: _____ Pharmacy Phone #: _____

_____

Medications to Be Transferred

Drug Name	Prescription #	Drug Name	Prescription #

Pharmacy Use Only Below This Line

Name of transferring Pharmacist or Tech: _____ Name of SCANA Pharmacist or Tech: _____

Pharmacy DEA Number: _____ Date: _____ Time: _____

Drug Name: _____	Drug Name: _____
NDC#: _____	NDC#: _____
Rx#: _____	Rx#: _____
Original Quantity: _____	Original Quantity: _____
Quantity Remaining: _____	Quantity Remaining: _____
SIG: _____	SIG: _____
_____	_____
Original Date: _____	Original Date: _____
First Fill Date: _____	First Fill Date: _____
Last Fill Date: _____	Last Fill Date: _____
Doctor's Name: _____	Doctor's Name: _____
DEA Number: _____	DEA Number: _____
Phone Number: _____	Phone Number: _____
Address: _____	Address: _____
_____	_____
Dispense As Written: _____ Substitution Permitted: _____	Dispense As Written: _____ Substitution Permitted: _____
Comments/Notes:	Comments/Notes: