GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS

DEPARTMENT OF HUMAN SERVICES

VI STATE PHARMACEUTICAL ASSISTANCE PROGRAM

PRESCRIPTION VERIFICATION FORM

(TO BE COMPLETED BY PHYSICIAN ONLY)

PATIENT INFORMATION

NAME ____
Last First Initial

DATE OF BIRTH_____________ PLACE OF BIRTH _____________

ADDRESS: (PHYSICAL) ____

(MAILING) ____

TELEPHONE NUMBER: (HOME) ____________ (WORK) ______________ (CELL) ______________

PHYSICIAN INFORMATION

NAME ____
Last First (PRACTICE/SPECIALTY)

ADDRESS: (PHYSICAL) ____

(MAILING) ____

TELEPHONE NUMBER: ____

A. **Please note any health problem, physical impairment, emotional difficulty, behavioral problem, or facts which may limit full participation in our State Pharmaceutical Assistance Program.**

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B. **Patient is subject to allergies:**

YES (__) NO (__)

Codeine____ Sulfa_____ Aspirin______ Other___________________

C. **Patient is subject to:**

__ asthma	__ sensitive skin	__ sleepwalking	__ nosebleed
__ ear ache	__ sinus trouble	__ convulsions	__ high blood pressure
__ fainting	__ frequent colds	__ headache	__ motion sickness
__ tonsillitis	__ nightmares	__ bed wetting	__ allergies
__ eye infection	__ bronchitis	__ kidney problem	(describe)______________

D. Patient wears contact lenses (__) or glasses (___)

Medical Conditions and Diagnosis: (Check all that apply)
High Blood Pressure _____ Diabetes _____ Arthritis _____
Cancer _____ Heart Lung _____
Other ____

____

E. To ensure that all patients comply with their medication regimen in a cost contained manner, please provide a list of the patient's CURRENT prescribed medication and the indication for its use.

Medication	Strength (mg)	SIG Directions	Prescribing Doctor	Doctor Phone #	Pharmacy Company	Date

NOTE: THE SPAP PROVIDES MEDICATION ASSISTANCE TO SENIORS AGE 60 AND ABOVE; TO ENSURE THAT WE PROVIDE ADEQUATE COVERAGE, WE ENCOURAGE PHYSICIANS TO PRESCIBE GENERICS UNLESS BRAND IS ABSOLUTELY NECESSARY!!!