Saliba's
Extended Care Pharmacy
An integral piece of your health care puzzle

21025 N. 8th Way
Phoenix, AZ 85024
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ALF Fax: (623) 815-1222 * SNF Fax: (623) 587-5715

New Admit

Patient Name: _____ DOB: _____ Social Security:_____

Allergies: _____ Diagnosis: _____ IV: _____ Yes ____ No ____

Facility Name: _____ Facility Phone: _____

Facility Address: _____ Facility Fax: _____

Dr. Name: _____ Dr. Phone: _____

Responsible Party: _____ Phone: _____

Responsible Party Address: _____

Credit Card # (Optional):_____ 3 Digit Security # (On back of card):_____Expiration Date: _____

Insurance Name: _____ Insurance ID #'s:_____ Insurance Group#_____

***** Copy of insurance card front and back is necessary for accurate billing *****

Please remember to fax a copy of the PATIENTS FACE SHEET along with any copies of CONTROLED SUBSTANCE PRESCRIPTIONS.

All medications listed below are for a 30-day supply. Twelve refills will be given unless otherwise noted.

Rx Number/medication	Strength	Qty	Directions	Refills
_____	_____	____	_____	_12__ or____
_____	_____	____	_____	_12__ or ____
_____	_____	____	_____	_12__ or ____
_____	_____	____	_____	_12__ or ____
_____	_____	____	_____	_12__ or ____

I certify that the attached admission orders have been VERIFIED with:
(All orders need to be verified with a facility MD/NP)

Dr. _____on (date) _____ at (time) _____

_____
Name of licensed nurse taking care of above patient

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