

## YEARLY UPDATED PRESCRIPTION DRUG LIST

This form is to be filled out by any practitioner who is prescribing you medications.  
**The Completed form must be mailed/faxed by the practitioner's office.**

\_\_\_\_\_  
(Printed Participant's Name)

Prescription Date	Type of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication

I have been informed that this patient is involved in a monitoring program. I understand that his/her drug(s) of choice is: \_\_\_\_\_

I have been informed that this patient is involved in a monitoring program. I understand that he/she has a diagnosis of: \_\_\_\_\_

\_\_\_\_\_  
Practitioner's Name (Please print)

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Practitioner's Phone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Practitioner's Address