DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

PHARMACY DISPENSING RECORD

D.C. Official Code § 7-661.01 *et seq*.

Email form to: deathwithdignitydc@dc.gov

A	**PATIENT INFORMATION**			
	PATIENT'S NAME (LAST, FIRST, MIDDLE):		DATE OF BIRTH:	
	SOCIAL SECURITY NUMBER	INSURANCE CARRIER	Used	Not Used

B	**PHYSICIAN INFORMATION**	
	NAME (LAST, FIRST, M.I.):	TELEPHONE NUMBER: ( ) —
	BUSINESS ADDRESS:	
	CITY, STATE AND ZIP CODE:	FAX NUMBER:

C	**DISPENSING PHARMACY INFORMATION**	
	PHARMACY NAME:	TELEPHONE NUMBER: ( ) —
	BUSINESS ADDRESS:	
	CITY, STATE AND ZIP CODE:	

D	**MEDICATIONS DISPENSED**		
	COVERED MEDICATIONS PRESCRIBED AND DOSE	**DATE PRESCRIBED**	**DATE DISPENSED**
	#1		
	#2		
	#3		
	#4		

PRINT NAME	TELEPHONE NUMBER ( ) —	DATE
SIGNATURE DISPENSING HEALTH CARE PROVIDER		

Immediately upon dispensing covered medication, the pharmacist shall notify the attending physician electronically and email this form to the Department of Health at deathwithdignitydc@dc.gov