Washington State Department of Health

PHARMACY DISPENSING RECORD

MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47856, Olympia, WA 98504-7856

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH:
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	

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

C	DISPENSING HEALTH CARE PROVIDER INFORMATION	
	NAME (LAST, FIRST, M.I.) AND TITLE:	TELEPHONE NUMBER: ( ) —
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	DATE OF THIS REPORT:

D	MEDICATIONS DISPENSED			
	MEDICATIONS	**QUANTITY**	**DATE PRESCRIBED**	**DATE DISPENSED**
	#1			
	#2			
	#3			
	#4			

E	SIGNATURE		
	DISPENSING HEALTH CARE PROVIDER'S ORIGINAL SIGNATURE	TELEPHONE NUMBER ( ) —	DATE