Darcy J. Hansen, MD
1145 19th St NW, Ste 210
Washington, D.C. 20036
Phone: (202) 223-6199
Fax: (202) 223-6799

Prescription Refill Form:

Patient Name: _____ DOB: _____

Daytime Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

(Please circle one of the following options)

Please have my prescription(s):

1. Faxed to my pharmacy at:
   Pharmacy Name: _____
   Pharmacy Fax Number:(_____) _____ - _____

2. Would like to pick-up at the office

3. Mailed to:

_____

_____

Prescription #1:
Name of Medication: _____
Strength of Medication: _____
Refills Requested: _____

Prescription #2:
Name of Medication: _____
Strength of Medication: _____
Refills Requested: _____

Prescription #3:
Name of Medication: _____
Strength of Medication: _____
Refills Requested: _____