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.

July 17, 2017