



NYU School of Medicine & Hospitals Center

# Department of Obstetrics and Gynecology

**NYU Obstetrics & Gynecology**  
530 First Avenue, Suite 5F  
New York, NY 10016  
Phone: 212-263-3049

Date: \_\_\_\_\_

## PRESCRIPTION REFILL FORM

Fax to 212-263-0616

**Patient Name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_

**Patient telephone number:** \_\_\_\_\_

**Pharmacy telephone number:** \_\_\_\_\_

Prescription #	Prescription Name	Strength	Number of pills	How taken

Office use only

**Date of last visit:** \_\_\_\_\_

**Prescription refill authorized by** \_\_\_\_\_

**Prescription refill not authorized patient needs to come in** \_\_\_\_\_

**Called in to pharmacy by** \_\_\_\_\_

**Patient contacted by** \_\_\_\_\_