Pharmacist's Report to Nebraska Parkinson's Disease Registry

Patient Information

Patient Name _____ *SSN __ __ __ - __ __ - __ __ __ __
Last Name, First Name Middle Initial

Patient Address _____ Date of Birth _ _/_ _/ _ _ _ _ *Gender M F
Street, Unit Number City State Zip Code (Circle One)

Physician Information

Physician Name _____
Last Name, First Name Middle Initial

Physician Address_____
Street, Unit Number City State Zip Code

Pharmacy Information

Pharmacy Name _____ Pharmacy Phone Number(__ __ __) - __ __ __ - __ __ __ __
Area Code

Pharmacy Address _____
Street, Unit Number City State Zip Code

**** PLEASE DO NOT REPORT PATIENT IF THE PHYSICIAN INDICATES THAT THE DRUG IS PRESCRIBED FOR RESTLESS LEG SYNDROME OR IF THE DRUG IS PRESCRIBED FOR EVENING OR BEDTIME USE ONLY.***

*****Optional

Thank you for your assistance in fulfilling the Public Health mission of Nebraska Revised Statute 81-697 to 81-6,110.

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Form PHARMPDR.FRM

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