## Pharmacist's Report to Nebraska Parkinson's Disease Registry

| Patient Information  |                      |            |              |          |                      |                |                             |  |  |  |
|--|----------------------|------------|--------------|----------|----------------------|----------------|-----------------------------|--|--|--|
| Patient Name   | ast Name, First Name |            |              |          | *S<br>Middle Initial |                |                             |  |  |  |
| Patient Address  | Street, Unit Number  | City       | State Zip Co |          | Date of Birth        | //             | *Gender M F<br>(Circle One) |  |  |  |
| Physician Information  |                      |            |              |          |                      |                |                             |  |  |  |
| Physician Name _   | Last Name,           | First Name |              |          | Middle Initial       |                |                             |  |  |  |
| Physician Addres   | S                    |            |              |          | wilddie initial      |                |                             |  |  |  |
| •  | Street, Unit Number  |            | City         |          |                      | State          | Zip Code                    |  |  |  |
| Pharmacy Information   |                      |            |              |          |                      |                |                             |  |  |  |
| Pharmacy Name  |                      |            | Ph           | armacy F |                      | )<br>Area Code |                             |  |  |  |
| Pharmacy Address   |                      |            |              |          |                      |                |                             |  |  |  |
|  | Street, Unit Number  |            | City         |          |                      | State          | Zip Code                    |  |  |  |
| * PLEASE <u>DO NOT</u> REPORT PATIENT IF THE PHYSICIAN INDICATES THAT THE DRUG IS PRESCRIBED FOR <u>RESTLESS LEG</u><br><u>SYNDROME</u> OR IF THE DRUG IS PRESCRIBED FOR <u>EVENING OR BEDTIME USE ONLY.</u> |                      |            |              |          |                      |                |                             |  |  |  |
| *Optional  |                      |            |              |          |                      |                |                             |  |  |  |
| Thank you for your assistance in fulfilling the Public Health mission of Nebraska Revised Statute 81-697 to 81-6,110.  |                      |            |              |          |                      |                |                             |  |  |  |

| Pharmacist's Report to Nebraska Parkinson's Disease Registry  |                           |                         |            |                        |                    |                  |  |  |  |  |
|---|---------------------------|-------------------------|------------|------------------------|--------------------|------------------|--|--|--|--|
|   |                           | Pa                      | tient Info | rmation                |                    |                  |  |  |  |  |
| FORM PHARMPUR.FRM   |                           |                         |            |                        |                    |                  |  |  |  |  |
| Patient Name  |                           |                         |            | *SSN                   |                    |                  |  |  |  |  |
|   | ast Name,                 | First Name              |            | Middle Initial         |                    |                  |  |  |  |  |
|   |                           |                         |            | Date of Bir            | th/_ /             | *Gender M F      |  |  |  |  |
|   | Street, Unit Number       | City                    | State      | Zip Code               |                    | (Circle One)     |  |  |  |  |
| Physician Information   |                           |                         |            |                        |                    |                  |  |  |  |  |
|   |                           | · ··,                   |            |                        |                    |                  |  |  |  |  |
| Physician Name  |                           |                         |            |                        |                    |                  |  |  |  |  |
|   | Last Name,                | First Name              |            | Middle Initial         |                    |                  |  |  |  |  |
| Physician Addres  | S                         |                         |            |                        |                    |                  |  |  |  |  |
|   | Street, Unit Number       |                         | City       |                        | State              | Zip Code         |  |  |  |  |
|   |                           | Pho                     | rmacy In   | formation              |                    |                  |  |  |  |  |
|   |                           | FIIC                    | armacy m   | TOTTILATION            |                    |                  |  |  |  |  |
| Pharmacy Name   |                           |                         | Pł         | narmacy Phone Numb     | er( )-             | -                |  |  |  |  |
|   |                           | Pharmacy Phone Number() |            |                        |                    |                  |  |  |  |  |
| Pharmacy Addres   | SS                        |                         |            |                        |                    | <del> </del>     |  |  |  |  |
|   | Street, Unit Number       |                         | City       |                        | State              | Zip Code         |  |  |  |  |
| * PLEASE <u>DO NOT REPORT PATIENT IF THE PHYSICIAN INDICATES THAT THE DRUG IS PRESCRIBED FOR RESTLESS LEG SYNDROME</u> OR IF THE DRUG IS PRESCRIBED FOR <u>EVENING OR BEDTIME USE ONLY.</u> |                           |                         |            |                        |                    |                  |  |  |  |  |
| *Optional   |                           |                         |            |                        |                    |                  |  |  |  |  |
| Thank you   | for your assistance in fu | Ifilling the Public     | c Health n | nission of Nebraska Re | evised Statute 81- | 697 to 81-6,110. |  |  |  |  |