Welcome

Goddard Health Center Pharmacy

Transfer Your Prescriptions
pharmacy@ou.edu

Print Name _____ OU ID Number _____

Address _____

City _____ State _____ Zip Code _____

Cell Phone # _____ Date of Birth _____

I understand that it is my responsibility to notify the pharmacy at the above telephone or address if my contact information changes.

Medication Allergy and Reaction:

_____

_____

Pharmacy Name _____

City _____ State _____ Phone Number _____

Prescription Insurance Information

Prescription Insurance Name _____ Cardholder ID # _____

BIN# _____ PCN# _____ Group# _____

If prescriptions have zero refills, please contact your provider and have new prescriptions sent to Goddard Pharmacy. Thank you.

Prescription Number	Medication Name	Date Needed

HEALTH SERVICES
The UNIVERSITY of OKLAHOMA

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