

**PRESCRIPTION INFORMATION**

INSTRUCTIONS: This form is to be used by all RPP Participants who require prescription medications. The completed form MUST be mailed by the healthcare provider only, to the address below or faxed to (803) 896-5710. If you have any questions, call (803) 896-5700 or toll free 1-877-349-2094. Please list all medications prescribed for your patient in the last year.

(Please Print) \_\_\_\_\_  
 PARTICIPANT NAME Recovery Specialist

DATE OF PRESCRIPTION	TYPE OF MEDICATION	QUANTITY & DOSAGE PRESCRIBED/NUMBER OF REFILLS	REASON FOR MEDICATION

I have been informed that this patient is being monitored by RPP for Health professionals for (check one)  Chemical Dependency  Dual Diagnosis  
 Healthcare Provider Information:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Facility: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Healthcare Providers Signature

\_\_\_\_\_  
 Date

440 Knox Abbott Dr., Suite 220, Cayce, South Carolina 29033  
 Telephone 803-896-5700 Toll Free 24hour helpline 1-877-349-2094  
 Fax (803) 896-5710