Vaccination Referral Form*

Date: ____________________

Patient's Name	**Patient's DOB**

Street Address	**City**	**State**	**Zip**

Take this form to your local pharmacy or to the one we recommended for you to receive your vaccine(s).

Pharmacy Name: ____________________ **Pharmacy Fax:** __________

Pharmacy Address: ____________________ **Pharmacy Phone:** __________

____

We've listed the vaccine(s) that we recommend below. The pharmacist will fill in the manufacturer name, lot #, and date after you receive it.

Vaccine Name	**Manufacturer & Lot #**	**Date Administered**
Vaccine Name	**Manufacturer & Lot #**	**Date Administered**

Pharmacist,
Once you have administered the above vaccine(s), please return via fax to our office so we can update our patient's records.

HCP Name: ____________________ **HCP Fax:** __________

HCP Address: ____________________ **HCP Phone:** __________

____

Signature of Prescriber	***State License #***	***DEA Number***

***Prescriber – This form is not designed to meet the prescription requirements in every state as these requirements vary. Please check the requirements in your state prior to utilizing this form as a prescription.**

Please note that pharmacy vaccination rules vary by state and not all pharmacists are able to administer ZOSTAVAX.

Copyright © 2014 Merck Sharp & Dohme Corp., a subsidiary of **Merck & Co., Inc.**
All rights reserved. VACC-1114133-0002 06/14