# Vaccination Referral Form*

DATE:

Patient's Name | Patient's DOB

Street Address | City | State | Zip Code

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

Pharmacy Name | Pharmacy Phone | Pharmacy Fax

Pharmacy Address | City | State | Zip Code

## Listed below are the vaccine(s) recommended for you. The pharmacist will fill in the manufacturers name, lot #, and date after you receive it.

Vaccine Name | Manufacturer & Lot # | Expiration Date | Date Administered

Vaccine Name | Manufacturer & Lot # | Expiration Date | Date Administered

Pharmacist

## Pharmacist, once you have administered the above vaccine(s), please return form via fax to the office so the patient's records can be updated.

HCP Name | HCP Phone | HCP Fax

HCP Address | City | State | Zip Code

Signature of Prescriber | State License # | DEA Number

***Prescriber/Pharmacist - 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.**

Additionally, laws and regulations concerning pharmacy vaccination vary by state.
Consult the appropriate resources, including the relevant state pharmacy board, for more information.

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US-NON-05782 07/20