Vaccination Referral Form*

DATE:

Patient's Name | Patient's DOB

Street Address | City | State | Zip Code

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

HCP Name | HCP Phone | HCP Fax

HCP Address | City | State | Zip Code

Listed below are the vaccine(s) recommended for you. The pharmacist will fill in the vaccine administration details.

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

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

Administrator Name

Pharmacist

Pharmacist, please fill in your information below.

Pharmacy Name | Pharmacy Phone | Pharmacy Fax

Pharmacy Address | City | State | Zip Code

Pharmacist

***This form was not designed to meet the prescription requirements in any state as these requirements vary. Additionally, laws and regulations concerning pharmacy vaccination vary by state. Consult the appropriate resources, including the relevant state pharmacy board, for more information.**

MERCK

US-NON-11236 08/22