



CHILDREN'S HOSPITAL

CHILDREN'S HEALTH SYSTEMS
PHARMACY REQUISITION--PEDIATRIC PRACTICE SOLUTIONS

fax to: 205-638-9794

DEPARTMENT: \_\_\_\_\_

DATE: \_\_\_\_\_

ACCOUNT # (REQUIRED): \_\_\_\_\_

ORDERED BY: \_\_\_\_\_

EXTENSION NO.: \_\_\_\_\_

Table with 4 columns: Medication, Pkg Size, Order #, Qty. Includes sections for INJECTABLES and ORAL MEDS.

Table with 4 columns: Medication, Pkg Size, Order #, Qty. Includes sections for OTIC/OPHTHALMIC, REFRIGERATOR, TOPICALS/MISC., and MISCELLANEOUS.

Check delivery method:
Order Mailed
Order Picked Up By (name):
Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_

FOR PHARMACY USE ONLY!
Order Filled By: \_\_\_\_\_ (Date)
Order Checked By: \_\_\_\_\_ (Pharmacist's Signature) (Date)