

Medication Transfer Request

Date: [Insert Date]

To: [Receiving Pharmacy Name]

Address: [Receiving Pharmacy Address]

Dear [Receiving Pharmacy Manager/Pharmacist],

I am writing to request the transfer of medication for the following patient:

Patient Name: [Patient Full Name]

Patient Date of Birth: [Patient DOB]

Prescription Number: [Prescription Number]

Medication Name: [Medication Name]

Quantity to Transfer: [Quantity]

Original Pharmacy Name: [Original Pharmacy Name]

Original Pharmacy Address: [Original Pharmacy Address]

Please feel free to contact me at [Your Phone Number] or [Your Email Address] if you have any questions or require additional information regarding this transfer.

Thank you for your assistance in this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Pharmacy Name]

[Your Pharmacy Address]

[Your Pharmacy Phone Number]