Patient Reported Medication Record

Upstate Neurology Consultants, LLP

Directions: Please complete the form below and bring it with you to your appointment with our neurologist. This will become part of your permanent record. This information MUST be accurate AND legible.

Name: _____

Date of Birth: _____

Allergies and Reaction: _____

_____

Note: We transmit prescriptions electronically so we need the following information:

Your Pharmacy's Name: _____

Your Pharmacy's address: _____

Your Pharmacy's telephone number: _____

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Continue on back of this sheet if necessary