

# Medical Contacts Worksheet



Please provide us with the information requested below to ensure that we have the correct information to respond to your medication requests and communicate with your physicians.

**Patient Name:** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

**Pharmacy Information: Where would you like prescriptions sent? CMA to enter into EPIC**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Primary Care Physician Information: Front Desk to enter into EPIC**

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Referring Physician Information: Who sent you to see us? Front Desk to enter into EPIC**

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Other Physicians: Do you have a gastroenterologist? Front Desk to enter into EPIC**

4. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ e-mail: \_\_\_\_\_

Specialty: \_\_\_\_\_

5. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ e-mail: \_\_\_\_\_

Specialty: \_\_\_\_\_

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