Faith Pharmacy

Saturdays 9:00 a.m. - 12:00 p.m.

CHECK IN: 8:45 – 10:30 AM ONLY

MUST HAVE REFERRAL & PRESCRIPTIONS (FAX: 859-272-0434)

NEW LOCATION: 230 South Martin Luther King Blvd

NEW PHONE: 859-272-0219, Parking is available.

Bring your prescription(s). MUST be written by an approved, referring healthcare provider and be from the Faith Pharmacy medications list. (List available on-line at Mission Lexington website)

Prescriptions are filled on a first-come, first-served basis.

No NARCOTICS, CONTROLLED SUBSTANCES, OR ANTIBIOTICS are available

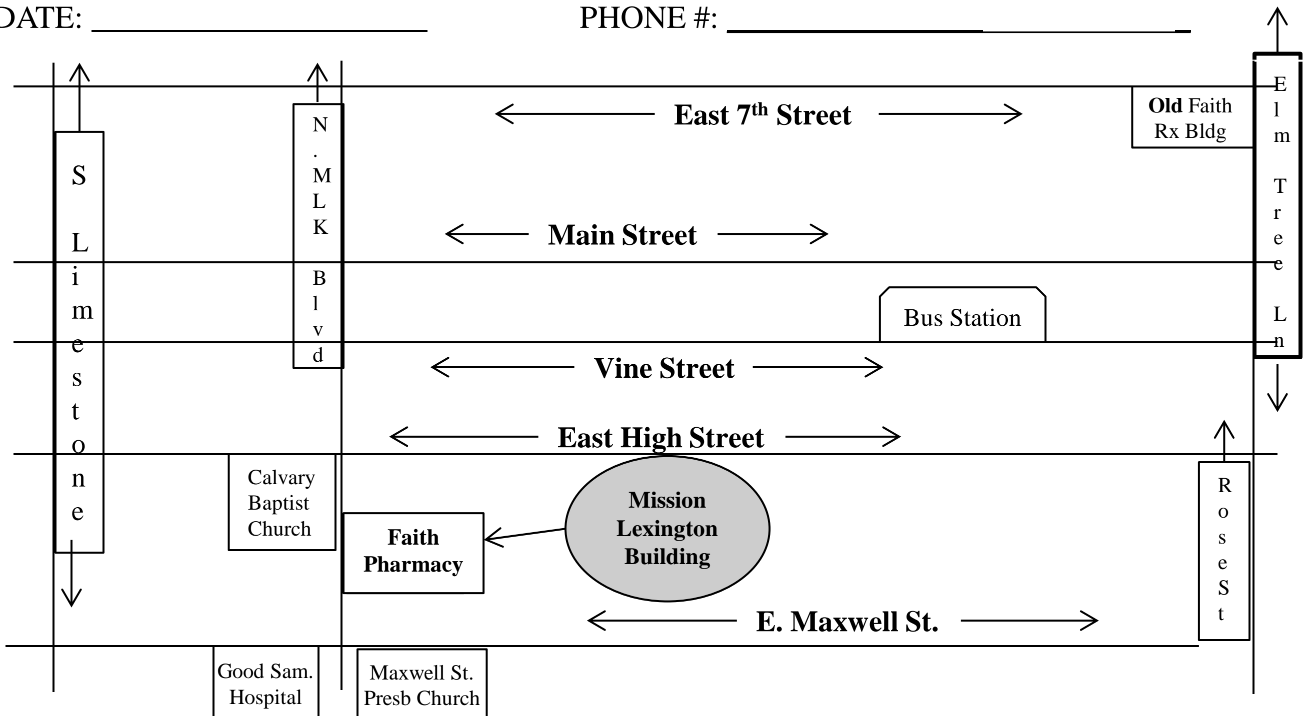
Faith Pharmacy is a joint mission effort of Maxwell Street Presbyterian Church and Christ the King Cathedral

PATIENT'S NAME: ____

REFERRING AGENCY: ____

SOCIAL WORKER OR INTERVIEWER: _______________________________

DATE: ________________ PHONE #: __________________



FAITH PHARMACY
Patient Information Sheet

Last Name: ______________________ **First Name:** ______________________

Date of Birth: ________ / ______ / ______ **Phone:** ______________________

Social Security or Individual Taxpayer Identification Number (ITIN): ______________

Street Address: ______________________ **Apartment #:** __________

City: ______________________ **State:** ______ **Zip Code:** __________

Referral Source (please circle)

Kentucky Clinic
Hope Center
Catholic Action Center
St. Joseph's Mobile Unit
MISSION LEXINGTON
Chrysalis House
Salvation Army
Health Department
Other: __________

Please List Your Current Medications:

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Are you allergic to any drugs? If so, please list:

______________ ______________ ______________

Please circle if you have a history of, or are being treated for, any of the following:

Alcoholism
Anxiety
High cholesterol
Depression
Congestive heart failure
Asthma
Heart disease
High blood pressure
Psychosis
Epilepsy
Liver disease
Kidney disease
Low blood count
TIAs
Diabetes
Lung disease
Stroke
Panic attacks
Other: __________

By signing below, I certify the following:

1) **the above information I supplied is correct to the best of my knowledge, and**
2) **I am currently NOT a member of a health insurance plan or medical assistance program that could help pay for my medication.**

Pt's signature

SIGNED: ______________________ **DATE** ____ /____ /____

PRINT NAME: ______________________

WITNESS: ______________________