Ilanka Community Health Center
705 Second Street – PO Box 2290
Cordova, AK 99574
Ph: 907-424-3622 Fax: 907-424-3275

PRESCRIPTION REFILL REQUEST

Please note there is a 48 hour turn around time on refill request.
This is not confirming a refill will be completed without further conversation from a nurse. This is a request and you may be asked to schedule an appointment before a refill is granted.

Patient Name: _____

Patient Contact #: _____ DOB: _____

Medication Name:
Dosage:
Quantity:
Prescribing Doctor:
Pharmacy:

Patient Signature: _____ Date: _____

For office use only:

ICHC Signature: _____

Scanned into Chart Date: _____