

**E-Prescribing Form**

**'X' The Doctor or Nurse Practitioner you see**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Dr. Mohamed Elrafei      | <input type="checkbox"/> Dr. Mary Switala, DNP       | <input type="checkbox"/> Carrie Prakope, PMHNP BC  |
| <input type="checkbox"/> Dr. Igor Gefter          | <input type="checkbox"/> Dr. Amanda Moroz, DNP       | <input type="checkbox"/> Mazie Trusty, PMHNP BC    |
| <input type="checkbox"/> Dr. Anna Kravtsov        | <input type="checkbox"/> Emily Coyle, PMHNP BC       | <input type="checkbox"/> Natasha Dillon, PMHNP BC  |
| <input type="checkbox"/> Dr. Leonid Kapulsky      | <input type="checkbox"/> Maripat Alger-Cottone,APN   | <input type="checkbox"/> Jessica Miglin, PMHNP BC  |
| <input type="checkbox"/> Dr. Emad Mounir          | <input type="checkbox"/> Mohamed Alhennawy,<br>PMHNP | <input type="checkbox"/> Teresa Omwenga, PMHN BC   |
| <input type="checkbox"/> Dr. Marina Haghour-Vwich | <input type="checkbox"/> Deborah Eid, PMHNP BC       | <input type="checkbox"/> Lillian Carnero, PMHNP BC |
| <input type="checkbox"/> Dr. Ruby Kapadia         | <input type="checkbox"/> Rupinder Kaur, PMHNP BC     | <input type="checkbox"/> Lina Muthoni, PMHNP BC    |

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

**Date:** \_\_\_\_\_

**Local Pharmacy Name & Address:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mail Order Pharmacy Name & Address**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Telephone #** \_\_\_\_\_

**Telephone #** \_\_\_\_\_

**List medications you are allergic to:**

- No known drug allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List current medications:**

**None**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_