**AHI Efax: (888) 553-5425**

| Rx Request | Patient |
|---|---|
| Dr. Name: _____<br>DEA #: _____<br>Tel: (  ) | Last Name: _____<br>First Name: _____<br>Address: _____<br>City: _____<br>State: ____ Zip: _____<br>Telephone: (  ) |
| Script:<br><br><br><br>Dr. Signature: _____ | |