Path For Triples		Michael Blank, Ph.D.
Patient Initials: ___ ___ ___	**Patient ID #:** ___ ___ ___ ___ ___	**Date** M: ___ ___ / D: ___ ___ / Yr: ___ ___ ___ ___
Interviewer Initials: ___ ___ ___		**Week #** **1** **12** **24** **36**

Part 9. PHARMACY REFILL DATA FORM

Instructions: The NHN will call the pharmacy to obtain information about refills at the initial visit, 3, 6, and 9 months.

Index Drug ___________________

Dosage ____________________

Frequency ____________________
(# of times/day)

Pharmacy Name: _____________________

Pharmacy Address: ____________________
____

Pharmacy Phone: _____________________

Dates of Refills in last 3 months:

Last refill date _____ / _____ / _____

Refill – 1 date ______ / _____ / _____ Number dispensed _____

Refill – 2 date ______ / _____ / _____ Number dispensed _____

Refill – 3 date ______ / _____ / _____ Number dispensed _____

Refill – 4 date ______ / _____ / _____ Number dispensed _____

Refill – 5 date ______ / _____ / _____ Number dispensed _____

Refill – 6 date ______ / _____ / _____ Number dispensed _____

Refill – 7 date ______ / _____ / _____ Number dispensed _____

Refill – 8 date ______ / _____ / _____ Number dispensed _____

Refill – 9 date ______ / _____ / _____ Number dispensed _____

Refill – 10 date _____ / _____ / _____ Number dispensed _____

Refill – 11 date _____ / _____ / _____ Number dispensed _____

Refill – 12 date _____ / _____ / _____ Number dispensed _____