Patient Consent Form

pharmdprescriptions.com

Name: _____ Date of birth: _____ Gender:_____

Address:_____

Contact number: _____ Email: _____

Allergies:_____

By signing this form, I release pharmdprescriptions.com, its affiliates, officers, directors, employees, and agents from all liability arising from my receipt of the services provided.

Signature: _____ Date: _____

_____

Primary care provider:_____

Address: _____

Phone:_____ Fax: _____

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Known Medical Condiions:

_____
_____
_____

Any Renal or Liver Issue? Yes__ No__

If Kidney Disease is present, what is your current eGFR? _____

If Liver problem is present, what is your Child-Pugh Score (if available)? _____

What is your current weight? _____

Please List the Current Medications You Are Taking:

_____
_____
_____
_____
_____
_____