

Item #AP52953

100/pad 5-1/2" x 4-1/4"

10 pads/pack \$19.72/pack

Transfer Prescription

Name _____ Transfer Date _____

Address _____

Original Rx # _____ Date Of Issue _____

Date First Filled _____ Original Refills _____

Refills Remaining _____ Date Last Refill _____

Pharmacy _____

Address _____

DEA # _____

Pharmacist Of Record: _____

Transferring _____

Receiving _____

Rx

May Substitute

Dispense As Written

Address _____

DEA # _____

Item #LW1

100/pad 4-1/4" X 5-1/2"

10 pads/pack \$11.45/pack

FOR _____

ADDRESS _____ DATE _____

Rx

DISPENSE AS WRITTEN ☐

REFILL _____ TIMES DR. _____

DEA NO. _____ ADDRESS _____

Item #TRANSFER-RX1

4-1/4" X 5-1/2"

100/pad - 5 pads/pack

\$10.95/pack

TRANSFER PRESCRIPTION	
NAME _____	TRANSFER DATE: _____
ADDRESS _____	DOB: _____
ORIGINAL RX# _____	
DATE OF ISSUE _____	
DATE FIRST FILLED _____	
DATE LAST FILLED _____	
ORIGINAL QUANTITY _____	
REMAINING QUANTITY _____	
ORIGINAL REFILLS _____	
REMAINING REFILLS _____	
PHARMACY _____	
ADDRESS _____	
PHONE NO. _____	
DEA NO. _____	
PHARMACIST OF RECORD: _____	
TRANSFERRING: _____	
RECEIVING: _____	
MAY SUBSTITUTE	DISPENSE AS WRITTEN
PREScriber NAME: _____	
ADDRESS: _____	
PHONE NO. _____	
DEA NO. _____	

Jays Company 1-800-647-5297 Recorder # TRANSFER-RX1

Item #TRANSFER-RX2

4-1/4" X 5-1/2"

100/pad - 5 pads/pack

(IN STATE REQUIREMENTS)

\$10.95/pack

TRANSFER PRESCRIPTION	
NAME _____	TRANSFER DATE: _____
ADDRESS _____	DOB: _____
ORIGINAL RX# _____	
DATE OF ISSUE _____	
DATE FIRST FILLED _____	
DATE LAST FILLED _____	
ORIGINAL QUANTITY _____	
REMAINING QUANTITY _____	
ORIGINAL REFILLS _____	
REMAINING REFILLS _____	
PHARMACY _____	
ADDRESS _____	
PHONE NO. _____	
DEA NO. _____	
PHARMACIST OF RECORD: _____	
TRANSFERRING: _____	
RECEIVING: _____	
DISPENSE AS WRITTEN	MAY SUBSTITUTE
PREScriber NAME: _____	
ADDRESS: _____	
PHONE NO. _____	
DEA NO. _____	

Jays Company 1-800-647-5297 Recorder # TRANSFER-RX2

Item #TRANSFER-RX3

4-1/4" X 5-1/2"

100/pad - 10 pads/pack

(MA STATE REQUIREMENTS)

\$10.95/pack

TRANSFER PRESCRIPTION	
NAME _____	TRANSFER DATE: _____
ADDRESS _____	DOB: _____
ORIGINAL RX# _____	
DATE OF ISSUE _____	
DATE FIRST FILLED _____	
DATE LAST FILLED _____	
ORIGINAL QUANTITY _____	
REMAINING QUANTITY _____	
ORIGINAL REFILLS _____	
REMAINING REFILLS _____	
PHARMACY _____	
ADDRESS _____	
PHONE NO. _____	
DEA NO. _____	
PHARMACIST OF RECORD: _____	
TRANSFERRING: _____	
RECEIVING: _____	
Interchange is mandated unless the practitioner writes the words "no substitution" in the space above	
ADDRESS: _____	
PHONE NO. _____	
DEA NO. _____	

Jays Company 1-800-647-5297 Recorder # TRANSFER-RX3

Prices are subject to change without notice