GREENVILLE
HEALTH SYSTEM

Glucometer / Supplies Discharge Prescription

701 Grove Road
Greenville SC 29605
Phone: (864) 455 – 8910
Fax: (864) 455-8403

Physician: ________________________________ **Date**: ____/_____ /_________

Patient Name: _____________________________ **DOB**: ___________________

Allergies: _________________________________ **Room Number**: ___________

☐ **Interpreter Required**

Address: ____

City: _____________________________________ **State**: ____________ **Zip**: _____________

Daytime Phone: (____) _______________________

Please fax FACESHEET with this prescription to (864) 455 – 8403
Service available Monday thru Saturday 9 am – 4 pm

Form Faxed By: ____

Phone Number: (____) _______________________**Fax Number**: (____) ____________________

RX

Glucometer, Test Strips, Lancets
Sig: Tests __________ times / day

Quantity: 1 month supply
Refills: 0

____ ____________________________________

DISPENSE AS WRITTEN **SUBSTITUTION PERMITTED**