# Family Care Clinic

D. Blayne Laws, M.D.

Office 972-875-6700 Fax 972-875-6790

**Name_____ Pharmacy _____☐90 days**

**DOB_____ Allergies: _____**

**☐Mail order ☐Local**

**OK to refill meds through _____**

| Date | Initials | Medication | Dose | Frequency | **Amount for 30/90 days** |
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