Bremo PHARMACY
LONG TERM CARE

Small Pharmacy...Big Hearts
www.BremoRX.com
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Toll Free 800.346.2058 / E-mail bremoltc@rairx.com

New Home Application

Name of Home _____

Address _____

City/State/Zip _____

Telephone _____ Fax _____

Administrator _____ Maximum Number of Clients ____

Provide different shipping address below if applicable:

_____

___Please indicate the times that you use in your facility for:

NOTE: The example times listed are our standard dose times. Please check here ___ ____ ___ to use the standard times.

Daily medications ____ (example 8AM)

Two times daily ____ ____ (example 8AM, 8PM)

Three times daily ____ ____ ____ (example 8AM, 4PM, 8PM)

Four times daily ____ ____ ____ ____ (example 8AM, 12NOON,4PM, 8PM)

Bedtime ____ (example 8PM)

Please indicate preferred medication packaging style:

____ Calendar Cards (single fill) ____ Multifill

Paper or electronic MAR (QuickMAR)? _____

Do you want physician order forms sent monthly? _____

Would you prefer PRN medications in bottles or count down cards? _____

How is this home licensed? ____ MHMR ____ DSS Assisted Living

____ DSS Residential Care ____ Other

Current Pharmacy Provider: _____ Contact Number: _____

Notes: