



Mypsychedelicpharmacy.com
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Date_____

Prescription Request. Please fill out the following form and submit for review/ confirmation. Shortly you will receive either a confirmation of the request or a letter asking for more information. The confirmation will allow you to confirm your request and allow us to prepare the actual order for shipment. Filing out the below form does not guarantee shipment of any medication or products. A complete review is needed prior to any preliminary prescription request confirmation.

Item_____

Dosage_____ Volume_____

Item_____

Dosage_____ Volume_____

Item_____

Dosage_____ Volume_____

Physician_____ Email_____

State Lic#_____ NPI#_____ DEA#_____

Physician signature_____

Patient Name_____ DOB_____ Email_____

Ship to - Name_____

Address_____

City_____ State_____ Zip_____

Ship via— Standard_____ X _____

Physician Instructions_____