Over the Counter Medications (FSA Prescription)
Patient Instructions and Prescription Form
(See Form on Page 2)

Starting on January 1, 2011, the new federal law requires a prescription for some of the
over-the-counter (OTC) medicines if you want to get reimbursed through your Flexible
Spending Account (FSA). Please refer to the patient fact Sheet for more information on
which OTC medications require prescription forms.

- **Date:** Patients should leave this blank. Prescription will be dated when it is signed
  by the physician.

1) **Patient** will fill in the following information on the prescription (please print with a pen):

- **Patient Name**
- **Registration Number:** 8 digit number on the UofM blue hospital card.
- **Date of Birth:** Patient’s birthday.
- **Phone Number:** Telephone number where we can reach you during the day.
- **Physician:** Put a check mark next to your doctor’s name.
- **Medication Name:** Name of the medicine EXACTLY as it appears on the box.
- **Strength:** Strength of the medicine can be found on the front of the box.
  If not, look under the active ingredients section.
- **Dose:** Dose means how many or how much of the medicine you take or use each
time.
- **Quantity:** Total number or amount of medicine per bottle or container.
- **Directions:** Number of times you take or use the medicine in a day.
  PRN means use as needed.

2) Drop off the completed OTC prescription form at the Canton Health Center or mail for
physician signature.

3) Our staff will contact you when the OTC prescription has been signed by your
physician.

4) If you have any questions, please contact us at 734-844.5400.
# Over the Counter Medications (FSA Prescription)

**Canton Health Center**
1051 N. Canton Center Rd.
Canton, MI 48187-5097
(734) 844-5400

<table>
<thead>
<tr>
<th>Date:</th>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>____________________________</td>
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<tr>
<td>Reg Number:</td>
<td>____________________________</td>
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<tr>
<td>Date of Birth:</td>
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<td>Phone Number:</td>
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<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>Dose</th>
<th>Quantity</th>
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<tbody>
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<td>times per day PRN</td>
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<td>times per day PRN</td>
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<td>4</td>
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<td>times per day PRN</td>
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</tbody>
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Refills: PRN

__________________________
Physician Signature