



University of Illinois Medical Center REQUISITION AND VOUCHER
at Chicago PHARMACY SERVICES

HOSPITAL PHARMACY SERVICE
UNIVERSITY OF ILLINOIS HOSPITAL
1740 W. TAYLOR RM. C-300
CHICAGO, ILL. 60612

PLEASE TYPE OR USE BALL POINT PEN AND PRINT

TC	C / E IND.	⑥ COMMIT. / REQUISITION NO.
63		

NOTE: ALL DEA items must be on a separate requisition

Department for Billing

DEPT. REQUISITIONING: _____

OF DEPARTMENT TO BE CHARGED)

NO. 1 DATE: Date Order placed

DELIVER TO: _____

Registrant's Name

(INDIVIDUAL'S NAME)

ROOM

(ROOM OR AREA)

(PHONE EXT. NO.)

NOTE: The above information MUST appear on all requisitions or they will not be accepted by Pharmacy Services

QUANTITY ORDERED	UNIT OF MEASURE	LINE	DESCRIPTION	EDP NO.	QUANTITY RECEIVED	UNIT COST AND UNIT OF MEASURE	COST EXTENSION
3	50mcgh	1	Fentanyl Transdermal Patch				
2	10ml	2	Ketaset (100mg/ml)				
1	5ml	3	Buprenex (0.3mg/ml x 5)				
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					
		16					

EXAMPLE

DO NOT WRITE BEYOND THIS LINE

ISSUING DIVISION (CIRCLE)					FILLED BY: _____	DATE: _____	A. STANDARD COST →
IP	PCC	EEI	ONC	DERM	PRICED BY: _____	DATE: _____	B. SERVICE COST →
					EXTENDED BY: _____	DATE: _____	C. TOTAL COST →

CHARGE (ACCOUNT NUMBER MUST CARRY THROUGH ON ALL COPIES) **CREDIT**

FOAPAL

FUND	ORGANIZATION	ACCOUNT	PROGRAM	ACTIVITY	LOCATION
2 - [] [] [] [] [] []	[] [] [] [] [] [] [] []	1 2 2 0 0 7	[] [] [] [] [] []	[] [] [] [] [] []	[] [] [] [] [] []
REQUIRED	REQUIRED		REQUIRED	OPTIONAL	OPTIONAL

REQUESTED BY: _____ (SIGNATURE)	DATE: _____	RECEIVED BY: _____	REQ #:
APPROVED BY: _____ (AUTHORIZED SIGNATURE)	DATE: _____	DATE: _____	HP-055959