



Physicians to Children, Inc.

21 Highland Avenue, Suite 100 • Roanoke, VA 24013 Telephone (540) 344.9213 • Facsimile (540) 345.7559

**MEDICATION REFILLS**

Dr. Name \_\_\_\_\_

Dear Parents: In order for us to serve you better, we would like you to answer the following questions before we can refill your child's stimulant medication. Please use this form instead of calling about your prescription refills.

1. Is his/her overall school progress satisfactory?  Yes  No

If not, list the problems. Tell us which school subjects are causing the most problems. Tell us if the problems are worse in the morning or in the afternoon: \_\_\_\_\_

Check here if there are major problems

2. Are there any side effects?  Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

3. Would you like the same number of tablets or capsules?  Yes  No

Name of medication \_\_\_\_\_

Dosage/strength of medication \_\_\_\_\_

When does the child take medication?  AM  Noon  PM

Prefer to **pick-up** prescription on date \_\_\_\_/\_\_\_\_/\_\_\_\_ (Please allow minimum 48-hour turn-around time.)

Prefer prescription mailed. Prescription date desired \_\_\_\_/\_\_\_\_/\_\_\_\_

Please enclose a **self-addressed stamped envelope** with this completed form in the attached blue envelope. **Please allow a seven-day turn around time.** Please do not mail this form until approximately one week before the desired date.

4. This form must be completed before we can refill your child's medication.

5. **Insurance information** \_\_\_\_\_  
(Required to meet Federal requirements for prescriptions)

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Signature of parent/guardian completing form: \_\_\_\_\_