For Office Use Only:

Check up: _____
Recheck: _____
Insurance: _____

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 and select location below.)**
Location to **pick-up** ☐ Roanoke ☐ Westlake
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: _____

NOTE: If you are mailing this form to our office, please allow at least 5 business days for our office to receive it.