Mail: 21 Highland Ave SE Suite 100, Roanoke, VA 24013 (If you are mailing this form, please allow 5 days for us to receive it)
Fax: 540-345-7559
Patient Portal: Select "Messages" and "Non—Urgent Medication Question" and attach this file to the message

MEDICATION REFILLS

Name of your child's doctor/provider: _____

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 to request your prescription refills.
Please be sure your child is seen every 4-6 months for medication rechecks and up-to-date on annual well visits to continue receiving medication.

1. Is your child's overall school progress satisfactory? ☐ Yes ☐ No
If no, list any problems your child is having. Which school subjects are causing the most problems? Are the problems worse in the morning or in the afternoon?: _____
_____

☐ **Check here if the problems are significant**

2. If your child experiencing any side effects? ☐ Yes ☐ No
If yes, please explain: _____
_____

3. Would you like the same number of tablets/capsules? ☐ Yes ☐ No (Quantity: _____)
Name of medication: _____
Dosage/Strength of medication: _____
When does your child take the medication (select all that apply): ☐ AM ☐ Noon ☐ PM

4. How would you like to receive your prescription? (select one of the options below)
☐ **Pick-up** prescription on _____/_____/_____ at: ☐ Roanoke Office
(Please allow a **48-72 hour** turn-around time)

☐Have precription **mailed** to me (desired date: _____/_____/_____)
Please enclose a **self-addressed stamped envelope** with this completed form. Please allow a **seven-day** turn around time.
Please do not mail this form until approximately one-week before the desired date.

☐Have prescription **electronically** sent to the pharmacy (desired date: _____/_____/_____)
Pharmacy name: _____ Pharmacy Phone: _____

5. Name of Insurance: _____
(Needed to meet Federal requirements for prescriptions)

Child's Full Name: _____Date of Birth:_____

Date: _____ Daytime Phone: _____

Name of parent/guardian completing form: _____

Signature: _____

For Office Use Only:

Check up: _____
Recheck: _____
Insurance: _____