

Capitol Pediatric & Adolescent Center, PLLC

ADD/ADHD Prescription Refill Request

Patient Name: _____ Date of Birth: _____

When requesting prescription refills, please answer the following questions and fax this form to: 919-787-3396. Please list a phone number where you can be reached or where we can leave you a message: _____. If you do not hear from us within 72 hours, you may come by the _____ office and pick up the requested prescription.

Today's Date: _____ # Doses on Hand: _____

Date of patient's last physical: ____/____/____ Date of patient's last office visit: ____/____/____

Which doctor wrote the last prescription for the medicine you are requesting to be refilled?

What is the name and amount/dose of the medicine you want refilled?

	<i>(Please Circle Yes or No)</i>	
Has your child experienced any side effects while taking this medication?	YES	NO
Has your child's appetite changed while on this medication?	YES	NO
Has you child lost weight since taking this medication?	YES	NO
Has your child complained of stomach aches while taking this medicine?	YES	NO
Has your child had headaches while on this medicine?	YES	NO
Has your child had sleep problems while on this medicine?	YES	NO
Have you noticed changes in your child's mood while on this medicine?	YES	NO
Has your child's behavior altered while on this medication?	YES	NO
Does your child behave differently when not taking this medication?	YES	NO
Does taking this medication make your child feel tired?	YES	NO
Does your child have tics while on this medication?	YES	NO
Does your child experience any other problems while taking this medicine?	YES	NO

Signed: _____ Phone #: _____
Parent or Guardian

<i>(For Office Use)</i>		
Chart # _____	Refill Authorized: Y	N MD _____
Med/Dose: _____	Sig: _____	
# Rx Written: _____	Parent Notified by: _____	Date: ____/____/____