

# Roswell Pediatric Center, P.C.

## Medication Refill And Request Form

One week prior to needing your prescription, mail this form and self-address stamped envelopes to Roswell Pediatrics. The prescription will be written and mailed within 48 hours of receiving the request. You may also fax or drop off this form for pick-up 48 hours later.

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Parent's Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ (H) \_\_\_\_\_ (W)  
Patient's Physician: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Medications: BE VERY SPECIFIC!

### Medication #1

\_\_\_\_\_  
(Brand or Generic?)  
Strength of Tablet \_\_\_\_\_ mg  
Amount and Times Given:  
1st Dose \_\_\_\_\_ mg at \_\_\_\_\_ (time)  
2nd Dose \_\_\_\_\_ mg at \_\_\_\_\_ (time)  
3rd Dose \_\_\_\_\_ mg at \_\_\_\_\_ (time)  
4th Dose \_\_\_\_\_ mg at \_\_\_\_\_ (time)  
Quantity of Pills needed: \_\_\_\_\_

### Medication #2

\_\_\_\_\_  
(Brand or Generic?)  
Strength of Tablet \_\_\_\_\_ mg  
Amount and Times Given:  
1st Dose \_\_\_\_\_ mg at \_\_\_\_\_ (time)  
2nd Dose \_\_\_\_\_ mg at \_\_\_\_\_ (time)  
3rd Dose \_\_\_\_\_ mg at \_\_\_\_\_ (time)  
4th Dose \_\_\_\_\_ mg at \_\_\_\_\_ (time)  
Quantity of Pills needed: \_\_\_\_\_

Have you scheduled your 6 month physician follow up appointment?  
If scheduled, give date  
\_\_\_\_\_  
 Permission Slip (school Authorization Form for Medication) needed? Yes / No  
 Questions/Comments  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have included a Self-Addressed Stamped Envelope. Please mail the prescription to me.  
 I would prefer to pick up the prescription at the office.  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Faxed form and would like to pick-up the prescription at the office on:  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Office Hours: 8:30-12:30 & 1:30-5:00