Medication Refill

Date: _____ **Doctor:** _____

Patient's Name: _____ **Patient's DOB:** _____

Medication: _____

Who Called: _____ **Call Back #:** _____

Last Physical: _____ **Last Med Check:** _____ **Next Appt:** _____

Pharmacy: _____

Please answer the following questions:

□ Yes □ No	Is the medication having the desired effects?
	Have you noticed any of the following:
□ Yes □ No	Tics?
□ Yes □ No	Severe appetite suppression?
□ Yes □ No	Sleep disturbances?
□ Yes □ No	Headaches?
□ Yes □ No	Tremors?
□ Yes □ No	Nausea or other stomach upsets?
□ Yes □ No	Marked rebound systems when the medication wears off?

_____ _____

PARENT SIGNATURE DATE

Comments or Concerns:

_____

_____

_____

DOCTOR USE ONLY:

Next visit for HT, WT, BP, & Pulse is due: _____

Prescription refilled today: _____

Update 08/01/2017

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