

**Medication Refill request Form**

**Parents: Below is a list of all the information we need to refill your medication. This may be used as a guideline while phoning or e-mailing a request to us or you may make copies and fill it out to be faxed directly to us at:**

**972-769-0035**

**Email: pharmacy@texaschildneurology.com**

**Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Medication:** \_\_\_\_\_

**\* Please note if the medication contains the letters XR or ER for the extended release medications\***

**Dosage:** \_\_\_\_\_

**Directions:** \_\_\_\_\_

**30 day supply**

**90day supply for mail order**

**Mail**

**Pick Up in Plano**

**Pick Up in Grapevine**

**\*\*\* Please note that ADD/ADHD medications CAN NOT be called into the pharmacy per Texas Laws. They must be picked up or mailed. \*\*\*\*\***

**Who is requesting the refill:** \_\_\_\_\_

**\*\*\*\*Please note that refills can take up to 48 hours to process so please plan accordingly. There is also a \$10.00 charge for all ADD/ADHD medication refills filled outside of a doctor's visit. Please use your mail order when available. We can then issue a 90-day and 30 day supply giving you four (4) months of medication, therefore cutting down on the amount of refills and cost. ADD/ADHD prescriptions also have an expiration date of seven (7) days after the date on the script. Please call your pharmacy and have them fax us a refill request on all medication refills other than the ADD/ADHD medications. Please note that past due balances and missed appointments may delay your refills. For billing questions please call 972-769-9000 ext 222. Thank You.**

**MasterCard**

**Visa**

**Credit Card Information: Card #** \_\_\_\_\_ **Exp Date:** \_\_\_\_\_

**Please indicate if you would like for TCN to keep the Credit Card information on file for future medication refill request only.**                      **YES**                      **NO**

**Signature** \_\_\_\_\_

**\*I authorize Texas Child Neurology to bill my credit card \$10.00 for the triplicate, and if applicable, any past due balance. \*** **Revised 6/2008**