PEDIATRIC ASSOCIATES, INC.
REQUEST FOR ADD/ADHD REFILL
FAX TO : (260)436-2703

DATE: _____

Patient name: _____

Patient Date of Birth: _____

Parents Names: _____

Contact Number: _____

Alternate Number: _____

Name of prescription being refilled? _____

Current Dose _____

How is patient doing? _____

Primary physician @ PAI _____

Date of last check up? _____

Date of next check up? _____

Brand Name or Generic? _____

To be picked up by: _____
(Note: Do not pick prescription up until notified that it has been written.)

_____ _____
Parent/Guardian signature Date

For office use only:

Request completed by: _____