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D.B.A...
The MIND
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Prescription Refill Request

Print this form and mail or fax it to our office. Please allow at least 24 business hours to process each request once it has been received. Any information not included will delay the processing time.

ADHD medicines and certain other controlled substances cannot be called in. The pharmacy must be presented with a new prescription each month. These prescriptions must be picked up at the front desk. *Scripts may be mailed to your home (no PO boxes) at your request but expect postal delays. Any scripts lost in the mail will not be replaced.

Patient's Name: _____DOB: _____
Cell Phone: (_____) _____ - _____

Pharmacy: _____
Pharmacy Phone: (_____) _____ - _____

Prescription #1: Name of Medication: _____
Strength: _____
Directions: _____
Amount/Count: _____
Refills: _____

Prescription #2: Name of Medication: _____
Strength: _____
Directions: _____
Amount/Count: _____
Refills: _____

Prescription #3: Name of Medication: _____
Strength: _____
Directions: _____
Amount/Count: _____
Refills: _____

FOR OFFICE USE ONLY:

Above Information Taken By: _____ Date: _____

Approved By Signature: _____ Date: _____