

DAVID W. MALKA, M.D., P.A.  
D.B.A...

The

**MIND**



MALKAINSTITUTE OF NEUROSCIENCE AND DISEASE

Dr. David W. Malka, Board Certified Neurologist  
Dr. Qin Gu, Board Certified Neurologist  
Linda S. Bark, MS, APRN, Advanced Practice Registered Nurse  
Jennifer D. Quinn, MS, APRN, Advanced Practice Registered Nurse

Main: 727-442-MIND (6463)  
Web: [www.malkainstitute.net](http://www.malkainstitute.net)

[ ] 7539 Medical Dr, Hudson, FL 34667  
(e): [office@malkainstitute.net](mailto:office@malkainstitute.net)  
(f): 727-863-6167

[ ] 11345 Cortez Blvd, Brooksville, FL 34613  
(e): [brooksville@malkainstitute.net](mailto:brooksville@malkainstitute.net)  
(f): 352-596-1855

[ ] 8140 Picton Way, Ste. 103, Trinity, FL 34655  
(e): [trinity@malkainstitute.net](mailto:trinity@malkainstitute.net)  
(f): 727-841-7963

### Prescription Refill Request

**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 as it is in the patient's best interest to be able to shop prices among area pharmacies. \*Scripts may be mailed to your home (no PO boxes) at your request but please expect postal delays. Any scripts lost in the mail will not be replaced.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Pharmacy: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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: \_\_\_\_\_

Prescriber's Name: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_