



**The Commons at Lake Hearn
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ADD/ADHD Prescription Refill Request

Please help us by making ALL ADD/ADHD Prescription Refill requests by Email, Mail or Fax using this form.

****PLEASE MAKE YOUR REQUESTS AT LEAST A WEEK IN ADVANCE SO YOUR CHILD WILL NOT RUN OUT OF MEDICATION.** We require a minimum of 3 business days to process your request once received.

We will write your prescriptions for 3 separate 30 day supplies unless you instruct us to do otherwise below. Please take 1 prescription at a time to the pharmacy and keep the other 2 in a safe place. The 2nd and 3rd prescriptions will have “Do Not Fill” before a specific date on them to avoid confusion for your pharmacist.

☐ I will pick up prescription

☐ Mail prescription to home address

Date of Request _____

Patient Name		Date of Birth		Date of last Check up	
Address					
Primary Phone Number					

Name of Medication: _____	Name of Medication: _____
Dose/Strength: _____	Dose/Strength: _____
Quantity: _____	Quantity: _____
Brand Necessary: _____ Yes _____ No	Brand Necessary: _____ Yes _____ No
30 Day Supply: _____ or 3x30 Day Supply _____	30 Day Supply: _____ or 3x30 Day Supply _____