Alabama Pediatrics

Prescription Refill Request Form**

Last Name: **First Name:** **Middle Initial:**

Date of Birth:

1) **Name of Medication:**
   Strength of medication:
   Example: Adderall XR, 10 mg. If entering multiple medications, please list each medication on a separate line.

2) **Name of Medication:**
   Strength of medication:
   Please complete another form if additional medicines are requested.

PHARMACY NAME:
PHARMACY ADDRESS:
PHARMACY PHONE NUMBER:

By signing this form, I confirm the information entered on this form is accurate. If my prescription refill request cannot be filled due to incorrect patient information, incorrect medication information, and/or incorrect pharmacy information, it is my responsibility to re-submit this form with the corrected information or call the office at 205-879-7888 during business hours to request this prescription. Forms with inaccurate information will not be processed.

By signing this form, I understand that it is my responsibility to check with my pharmacy to ensure the medication is in stock. In the event that that the pharmacy does not have the medication in stock, I must locate a pharmacy that has the needed medication in stock and re-submit this form with the new pharmacy information.

By signing this form, I certify any patient well checks and/or med checks required for this medication are-up-to date. If not, it is my responsibility to call 205.879.7888 during normal business hours to schedule an appointment.

Name of Person Completing Form:

Signature of Person Completing Form:

Date:

ALLOW TWO BUSINESS DAYS FOR REFILL REQUESTS TO BE PROCESSED.

** This form may not be processed for refills if there are changes to the prescription. Also, an appointment may be required to refill some medications