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MEDICATION REFILL REQUEST SHEET

THIS FORM MUST BE RETURNED 5 TO 7 DAYS PRIOR TO THE EXPECTED DATE OF PICKUP

PATIENT NAME: _____ DATE: _____
YOUR NAME: _____ RELATIONSHIP TO PATIENT: _____
CAREGIVER'S NAME: _____ DAYTIME PHONE #: _____

Please mark the medication refill needed:

- Ritalin
- Dexedrine
- Clonidine
- Imipramine
- Adderall
- Adderall XR
- Medadate CD-ER
- Concerta

Dose of Medication: _____

Times Medication Given: _____

Number of Pills Needed (if 1 month supply or
amount insurance will pay for): _____

() Your child needs a recheck/annual physical in _____. Please call for an appointment.

() I would like to have the medical staff call me regarding this refill.

Prescription to be (mark one):

- Picked Up
- Mailed to Home
- Mailed to Pharmacy

Address To Mail To:

How is your child doing in school?

Any comments, complaints or changes recommended from your child's teacher (s)?

How does your child function at home?

How is your child's appetite?

How is your child sleeping?

Has counseling been recommended? Y N If yes, who is your child's counselor? _____
If yes, how is counseling going? _____

YOU CAN DROP THIS FORM BY THE OFFICE, MAIL IT (ALLOW EXTRA TIME), OR FAX IT TO THE MONTROSE OFFICE AT (970) 249-8897 OR THE DELTA OFFICE AT (970)874-7554 REMEMBER TO COMPLETE THIS FORM 5 TO 7 DAYS BEFORE IT IS NEEDED TO BE PICKED UP.