

NORTHERN VIRGINIA PEDIATRIC ASSOCIATES, P.C.

Amin J. Barakat, MD, Bassam A. Atiyeh, MD, Diane L. Halpin, MD, Ely G. Mouchahoir, MD, Lisa S. Kelly, MD, Christine Z. Baldrate, MD, Susan E. Henrikson, MD, Catherine J. Bae, MD, PAC, Hannah Woodley PAC, Sally Rader PNP, Elizabeth Nelson, CFNP

Prescription Refills and Order Form

Patients needing ADHD medications must be seen every month until the medication and dose have been established. After that, we can prescribe medications for up to 90 days at a time. Patients should be seen at least every 3 months for the first year of treatment and at least every 6 months each year after that. Patients also need to be seen if there is a change of dose or a change of medication.

*For **schedule II prescriptions** please fill out the form completely and accurately. Five working days may be needed for prescriptions to be completed. The prescription cannot be called to your pharmacist. Outside a visit, a fee of \$15.00 will be due.*

Please, use one form for each prescription.

Child's Name (last, first): _____

Date of Birth: _____

Phone Number: _____

Mailing address (if you want the prescription mailed): _____

Pharmacy Name and Phone #: _____

Doctor's name: _____

Name of medication (May copy from an old bottle, include LA, XR, ER or regular): _____

Please enter one: Generic or Brand: _____

Enter one: Tablet, capsule or syrup: _____

Dose of medication (include units like mg, ml, etc): _____

Times given per day (enter one): Once, Twice or three times: _____

Days needed per prescription (10, 30, 60 or 90): _____ days

If ninety days needed: do you want 1 (90) day prescription or 3-(30) day prescriptions: _____

Office use only:

Date received: _____ **Date completed:** _____, **Date notified:** _____