Medicine Refill Request Form

Return this form to the clinic THREE WEEKS BEFORE your medicine is finished.

You can bring a copy to the office
OR
Fax a copy to: 678.280.6635

Your order will **NOT** be processed without **ALL** the requested information

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Today's Date:	
Patient's Name:	
Date of Birth:	Phone #:
Name of Medicine & Dosage:	
How much / How often is this taken?	
How do you want your prescription filled? (check one)	
☐ Call in to pharmacy	☐Written Prescription
Pharmacy Name:	Date of Patient Pick-UP:
Pharmacy Number:	Patient Signature:

OFFICE USE ONLY

Provider Action: ☐Disp. # _____ with _____refills ☐Refill once & schedule appt. ☐No Refills until patient is seen	Date Completed: _____ Signature: