NORTHEAST PEDIATRIC ASSOCIATES, P.C.______

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BARCLAY MEDICAL PLAZA
75 BARCLAY CIRCLE, SUITE 115
ROCHESTER HILLS, MI 48307
TELEPHONE 248-856-6300
FAX 248-856-6303

PLEASE TEXT FORM TO 248-856-6300 FOR FASTEST RESULTS
****FILL OUT ENTIRE FORM WITH FULL PHARMACY ADDRESS****

Dear Parents,

We have had a dramatic increase in the number of prescriptions filled by our office. In order to diminish the possibility for error we are asking you to follow these guidelines. This will expedite the filling of the prescription and reduce the possibility for error.

- Make sure to MAIL OR FAX (248-856-6303) or text a picture of refill to 248-856-6300.
- Allow us 3 days to fill the prescription. (Allow adequate time if it is to be mailed back to you.)
- Please be sure to include ALL of this information on the slip below.
  1. CHILD'S NAME
  2. Drug and Dosage (i.e., ADDERALL OR RITALIN)
  3. DATE NEEDED ON THE PRESCRIPTION
  4. Choose MAIL, PICK UP or ELECTRONIC – Please give your mailing address Pharmacy name & phone number every time you need a refill. If picking up, please give us the date and time you will be arriving.

Be aware that your child will require an ADD EVALUATION at least semi- annually in order to adequately monitor his/her progress. Remember that these are longer appointments that require special scheduling times.

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Your cooperation is greatly appreciated by our staff. Our goal is to provide the best care for your child.

TODAY'S DATE____________ PATIENTS NAME: __________________________________(DOB)________________

DRUG REQUESTED:____

DOSE & FREQUENCY:__________________________________ 30 day RX _____ 90 day RX*______

*Check with your insurance company to see if a 90 day prescription option is part of your plan.

PICK UP DATE/TIME: ____________________________________ NAME: _________________________

Mail ADDRESS:___________________________CITY/STATE:___________________ ZIP: ________

ESCRIBE PHARMACY NAME____

ADDRESS____

CITY/STATE____

Parent Name: _____________________________________ Phone #: __________________________

NURSE NAME:____ DATE:______________________