## ahp AUSTIN HEALTH PARTNERS

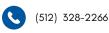
## ADHD MEDICATION REFILL REQUEST QUESTIONNAIRE

Today's date:	
Patient's Name:	Patient's DOB:
Person Making Request:	Relationship to Patient:
Name of Medication:	Dosage:

Is your child's academic performance improved on the medication?		No
Is your child's behavior/functioning at home improved on the medication?		No
Is your child's appetite acceptable on the medication?		No
Is your child sleeping normally on the medication?		No
Is your child having any stomach issues?		No
ls your child having any headaches?	Yes	No
Is your child having any mood swings?		No
Is your child having any tics?		No
Do you think the dosage of the medication needs to be changed?		No
Do you think the medication needs to be changed to a different medication?		No
Is your child experiencing any unpleasant side effects?		No

If yes, please explain:

Please allow at least 72 hours for your doctor to review this questionnaire and write your prescription.



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