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:________________________

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

If yes, please explain:

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

(512) 328-2266

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