

**Texas Child Neurology, PLLC  
Medication Refill Request Form**

**Parents: Below is a list of all the information we need to refill your medication.  
This may be used as a guideline while phoning or e-mailing a request to us or you  
may make copies and fill it out to be faxed or directly to us at:**

**972-769-0035**

**Email: [pharmacy@texaschildneurology.com](mailto:pharmacy@texaschildneurology.com)**

**Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Medication:** \_\_\_\_\_

\* Please note if the medication contains the letters XR or ER for the extended release medications\*

**Dosage:** \_\_\_\_\_ **Directions:** \_\_\_\_\_

30 day supply

90day supply for mail order

Mail

Pick Up

**Please note that Schedule II medications CANNOT be called into the pharmacy or  
faxed per Texas Laws. They must be picked up or mailed.**

**Who is requesting the refill:** \_\_\_\_\_

\*\*\*\*Please note that refills can take up to 48 hours to process, please plan accordingly. There is also a \$10.00 charge for all Schedule II medication refills requested outside of a doctor's visit. Please use your mail order when available. We can then issue a 90-day and 30 day prescription giving you four (4) months of medication, therefore cutting down on the amount of refills and cost. Schedule II prescriptions also have an expiration date of twenty one (21) days after the date on the prescription. Please call your pharmacy and have them fax us a refill request on all medication refills other than Schedule II medications. Please note that past due balances and missed appointments may delay your refills. For billing questions please call 972-769-9000 ext 222. Thank You.

Note: Most all ADD/ADHD medication are Schedule II.

MasterCard

Visa

**Credit Card Information: Card #:** \_\_\_\_\_ **Exp Date:** \_\_\_\_\_

**Please indicate if you would like for TCN to keep the Credit Card information on  
file for future medication refill request only.**       YES       NO

**Signature:** \_\_\_\_\_

I authorize Texas Child Neurology to bill my credit card \$10.00 for the triplicate, and if applicable, any past due balance.