17742 Beach Boulevard, #240, Huntington Beach, CA 92647 (714) 842-0444 FAX (714) 842-8444

ADD/ADHD MEDICATION REFILL REQUEST QUESTIONNAIRE

Today's Date ______________________________

Patient's Name ___________________________________ Date of Birth______________________

Address ____

Name of Medication ____

Dosage ____

As a courtesy to our patients we provide refills for medications for ADD/ADHD. We ask that this questionnaire be completed by a parent regarding the efficacy of the medication and any side effects your child might be experiencing in order to best tailor the medication type and dosing for your child. We prefer this form be filled out with at least every third month medication refill request. We require to see your child in the office for an appointment periodically depending on your child's individual needs.

Please answer the following questions:

Yes ___ No ___ 1. Has your child been evaluated in our office for ADD/ADHD in the last 6 months?

Yes___ No ____ 2. Has your child been/being evaluated by a psychologist/psychiatrist?

Yes___ No_____ 3. Is your child's academic performance improved on the medication?

Yes___ No_____ 4. Is your child's behavior/functioning at home improved on the medication?

Yes____No_____5. Is your child's appetite acceptable on the medication?

Yes____No_____6. Is your child sleeping normally on the medication?

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? If so, please describe:

____

Please allow at least 48-72 hours for your doctor to review this questionnaire and write your prescription. Your doctor will let you know when it is time to come in for a medical evaluation for your child.

I agree to the above medical policies regarding my child's medication refill and filled out this form to the best of my ability.

Parent Signature ____