Atlantic Health System

Essex Morris Pediatrics
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Attention Deficit Hyperactivity Disorder Refill Questionnaire

Last Pill Date _____ Refill for the month of _____

Name of Patient **Patients Date of Birth** **Today's Date**

_____ _____ _____

Name of medication and dosage _____

(1) Has the patient been taking the medication on regular basis? YES/NO

(2) Is the medication still effective? YES/NO

(3) Any current school issues? YES/NO

(4) Any current home issues? YES/NO

(5) Is the patient pregnant or lactating? YES/NO

(6) Is the patient on any current medications?
(Please list medications below)

Name of person completing form **Relationship to Patient**

_____ _____

Phone # _____

**** Please Allow 3-5 Business Days for Refill****

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