Prescription Refill Request

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49 Derry Road (Route 102)
Hudson, NH 03051-4027

Phone 603-889-4422 Fax 603-889-5544

Please fill in all the areas of this form including a signature of the person making the request. Then fax it to the office at 603-889-5544 (at this time privacy regulations due not allow emailing patient information on an insecure web site server). If you have not heard back from the office within 5 business days, please call to be sure we have received the information. Up to three medications for the child may be requested with each form. You may also use the after-hours office phone messaging to leave a refill or referral request, please include all the information listed on this form. If the prescription is needed immediately, please call the office.

Patient's name: _____ Birth date: _____

Person making request: _____

Contact phone number: _____

Pharmacy name/location: _____ Phone: _____

Please circle: Pick Up Script / Phone script to pharmacy

Prescription Information

Name of Medication: _____ Dose: _____

Prescription directions: _____

Prescription Information

Name of Medication: _____ Dose: _____

Prescription directions: _____

Prescription Information

Name of Medication: _____ Dose: _____

Prescription directions: _____

Your signature: _____ Date: _____

Some insurance companies require prior authorization for certain medications, even with refills of medications that have been prescribed previously. Please check with the office if your prescription refill has not been completed by the pharmacy within 2 days of your request.

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