# Innovative Family Care

## Medication Refill Request

Name:_____ Date:_____

Name of the Medication:_____

Dose:_____ How often you take this:_____

(note if your insurance pays for 90 days please indicate this)

_____ check if 90 day

The Provider who ordered this:_____

The Pharmacy you use:_____

Please allow 72 hours for the medication refill to be processed, after you leave the form. If the refill is an emergency make a notation. Please check with your pharmacy to see if the medication is ready. (Remember it is the patients responsibility to know when their medication is due to be refilled while taking an active role in your care.)

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