**PILOT** **Albuquerque, New Mexico**

**Patient:** ______________________________________
**MR #:** ______________________ **DOB:** ____/____/____
**Caller:** ______________________________________
☐ mother ☐ father Other: ______________________
**Phone** – Day: ______________________
Evening: ______________________

**CALL Received** – Date: _____/____/____ Time: ______
**Taken by:** ________________________________
**Provider:** ________________________________
**DATE –** Last seen: ____________ Last refilled: ____________
**Pharmacy:** ________________________________
Phone #: ___________________________

**A.D.D. / STIMULANT Medication Refill**

- ☐ **Adderall** ______ mg
- ☐ **Adderall XR** ______ mg
- ☐ **Concerta** ______ mg
- ☐ **Dexedrine** (regular) ______ mg
- ☐ **Dexedrine** (spansule) ______ mg
- ☐ **Metadate CD** ______ mg
- ☐ Methylphenidate **Ritalin**(regular) ______ mg.
- ☐ **Ritalin** (sustained release) 20 mg

**Current dose:**
Morning: ________________________________
Noon: ________________________________
Afternoon: ________________________________
**Quantity requested:** _______ month(s) supply

**Prescription -** ☐ will be picked up
☐ mail (please fill out and address envelope)

**Nurse entry for A.D.D. Medications**
**Spoke with:** ______________________________ ☐ mother ☐ father Other: ______________________

- ***How is medication working at home?*** ☐ *well* ☐ *fair* ☐ *poorly* ______________________________
- ***How is medication working at school?*** ☐ *well* ☐ *fair* ☐ *poorly* ______________________________
- ***Side effects****(check all that apply):* ☐ abdominal pain ☐ appetite suppression ☐ headache ☐ sleep disturbance ☐ tics

**Nurse signature:** ______________________________ **Date:** ____/____/____ **Time:** ______

**RESPIRATORY Medications**

- ☐ **Advair** ☐ 100/50 ☐ 250/50 ☐ 500/50
- ☐ **Albuterol** (Proventil, Ventolin) ☐ Inhaler ☐ Neb solution
- ☐ **Allegra** ☐ 30 mg tab ☐ 60 mg tab ☐ 180 mg tab
- ☐ **Claritin** ☐ 10 mg tab ☐ Syrup _______ ml
- ☐ **Flonase** nasal inhaler
- ☐ **Flovent** ☐ 44 mcg ☐ 110 mcg ☐ 220 mcg
- ☐ **Pulmicort** ☐ 0.25 mg ☐ 0.5 mg ☐ Turbohaler

**Current dose:** ______________________________
**Frequency:**
☐ 1 x / day
☐ 2 x / day
☐ every 4 hrs

**Quantity requested:** _______ month(s) supply

**Nurse entry for Asthma Medications**
**Spoke with:** ______________________________ ☐ mother ☐ father Other: ______________________

- ***Does your child use albuterol inhaler more than 2 times/week?*** ☐ *No* ☐ *Yes*
- ***Does your child awaken at night with asthma more than 2 times/month?*** ☐ *No* ☐ *Yes*
- ***Do you refill your child's albuterol inhaler more than two times/year?*** ☐ *No* ☐ *Yes*

**Nurse signature:** ______________________________ **Date:** ____/____/____ **Time:** ______

| **OTHER MEDICATIONS** | | | | |
|---|---|---|---|---|
| Current dose: | | | | |
| Frequency: | | | | |
| Quantity requested: | | | | |

**PROVIDER PLAN** - ☐ chart called for

☐ dispense as written ☐ # of refills: ________
☐ dispense with the following changes:
______________________________
☐ Nurse to call in
☐ Taken care of by provider

☐ recheck patient in ______ weeks / months
**NOTES:** ________________________________
________________________________
________________________________
**Provider signature:** ________________________ Date:___/___/___

**PEDIATRIC MEDICATION REFILL REQUEST**