The Women's Centre for Well Being
MEDICATION REFILL REQUEST

Please read the instructions carefully and answer each question fully Incomplete forms cannot be processed!!

Please use a separate form for each medication

- To request a medication refill by fax, please complete the following information and fax to 832.813.0984. Or contact your pharmacy for a fax request.
  - Refill requests received before noon Monday through Thursday will be called to your pharmacy by 5:00PM and on Friday by 12 noon.
  - Refill requests received after 12 noon or during the weekends or on a holiday will be phoned in by 12 noon on the next business day.
  - Before going to your pharmacy, we recommend you call them to be sure that your prescription is ready.
- Please be aware that prescriptions **cannot** be refilled by the emergency on call doctor, if you are past due for an appointment and have not scheduled, or for treatment of acute illness without an office visit. (e.g., bladder or vaginal infections).
- If you are running out of refills on maintenance medications, please check to see if you are past due for an office visit. Usually, you will be given enough refills to last until your next visit. If you are due for a visit, **do not use this form**; instead **call** the office during regular hours to schedule your visit. Let them know at that time if you need a medication refill.

NAME: _____

DATE OF BIRTH: _____

MEDICATION: _____
DOSE: _____
SUPPLY NEEDED (i.e. number of days of medicine): _____days

NAME and PHONE NUMBER of pharmacy with area code:
_____
CONTACT PHONE NUMBER where you may be reached if we have questions (include your area code): _____

I give permission for The Women's Centre for Well Being to call the above phone number for questions regarding my medication. Medical information or questions may be left at this number via voice mail if I am not available. If you do not wish medical information left at this number, it may delay your refill request.
Signature _____ _____
(May be signed by patient, parent or legal guardian of minor child)   Date

For TWCFWB use only
Time Received: _____
Approved by: _____
Called to Pharmacy by: _____
Date and time: _____