



Medication Refill Request

Today's Date: _____

Patient Information

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Preferred Pharmacy: _____

Medication

1. Medication Name: _____

Dose/Strength: _____

How are you taking it / frequency? _____

2. Medication Name: _____

Dose/Strength: _____

How are you taking it / frequency? _____

Medication refill requests may take up to **3 business days to process**. Please plan ahead and contact our office before running out of your medication. Your provider may require you to schedule a visit before a refill will be processed. All controlled substance refill requests require an appointment, as outlined in your signed Controlled Substance Agreement. Please contact our office for any medication changes or if you experience any adverse effects.

Patient/Guardian Signature

Date

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Email: reception@GoldenHeartMedicalllc.com