

**THIS FORM REQUIRED FOR ALL
FOLLOW-UP VISITS AND/OR PRESCRIPTION REFILL REQUEST**

Patient's Name _____ Birth date _____ Date _____
Day Phone _____ Doctor's Name _____

****Circle all currently prescribed medications, dosage in mgs., number of tablets each dose, and time of day given.**

| <u>MEDICATIONS</u> | <u>Mgs</u> | <u>#TABLETS EACH DOSE</u> | <u>HOUR GIVEN</u> |
|---------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------|-------------------|
| <u>M - Adderall(Amphetamine salts) tabs.</u> | <u>5, 7.5, 10, 12.5, 15, 20, 30 mg</u> | | |
| <u>M - Adderall XR(Dextroamphetamine) caps.</u> | <u>5, 10, 15, 20, 25, 30 mg</u> | | |
| <u>Adzenys XR ODT tabs.</u> | <u>3.1, 6.3, 9.4, 12.5, 15.7, 18.8mg</u> | | |
| <u>Daytrana Patch patch</u> | <u>10,15,20,30 mg</u> | | |
| <u>Methylphenidate regular tabs.</u> | <u>5, 10, 20mg</u> | | |
| <u>Methylphenidate SR tabs.</u> | <u>20mg</u> | | |
| <u>M - Ritalin – regular tabs.</u> | <u>5, 10, 20mg</u> | | |
| <u>Ritalin – SR tabs.</u> | <u>20mg</u> | | |
| <u>M - Ritalin – LA cap.</u> | <u>20, 30, 40 mg (10,60 w/PA)</u> | | |
| <u>M - Concerta (methylphenidate ER) tabs.</u> | <u>18, 27, 36, 54 mg</u> | | |
| <u>M - Focalin tabs.</u> | <u>2.5, 5, 10 mg</u> | | |
| <u>Focalin X caps.</u> | <u>5,10,15,20, 25, 30, 35, 40 mg</u> | | |
| <u>M - Intuniv tabs</u> | <u>1,2,3,4mg</u> | | |
| <u>Metadate ER tabs.</u> | <u>20 mg</u> | | |
| <u>M - Metadate CD caps.</u> | <u>10, 20, 30, 40, 50,60 mg</u> | | |
| <u>M - Methylin tabs.</u> | <u>2.5, 5, 10 mg</u> | | |
| <u>Methylphenidate ER caps.</u> | <u>10 mg, 20mg</u> | | |
| <u>Quillivant XR (25mg/5cc)</u> | <u>please write in your child's dosage)</u> | | |
| <u>M - Strattera caps.</u> | <u>10, 18, 25, 40, 60, 80, 100mg</u> | | |
| <u>M - Vyvanse caps., chewables</u> | <u>10, 20, 30, 40 , 50, 60,70 mg</u> | | |
| <u>Other medications that you would like to be filled (include dose and times per day):</u> | | | |
| _____ | | | |

M=Covered by Molina (generic, with age/dosage restrictions)

Below are a number of common problems that children have. Please rate each item according to your child's behavior in the last month.

| | NOT TRUE | JUST A LITTLE | OFTEN TRUE | VERY TRUE |
|-----------------------------------------------|----------|---------------|------------|-----------|
| 1. Weight loss/appetite loss | 0 | 1 | 2 | 3 |
| 2. Sleep problems/drowsiness | 0 | 1 | 2 | 3 |
| 3. Headaches/stomachaches | 0 | 1 | 2 | 3 |
| 4. Quick, dramatic mood changes | 0 | 1 | 2 | 3 |
| 5. Cries often, easily | 0 | 1 | 2 | 3 |
| 6. Restless, fidgets, tics | 0 | 1 | 2 | 3 |
| 7. Demands must be met immediately, impulsive | 0 | 1 | 2 | 3 |
| 8. Social withdrawal | 0 | 1 | 2 | 3 |
| 9. Temper outburst, defiant | 0 | 1 | 2 | 3 |
| 10. Fails to finish things he/she starts | 0 | 1 | 2 | 3 |
| 11. Inattentive, easily distracted | 0 | 1 | 2 | 3 |

How is your child performing in class? _____

FOLLOWUP APPOINTMENTS DUE EVERY 6 MONTHS – PLEASE SCHEDULE APPROPRIATELY

Parent Signature _____ Please circle one: pickup/date _____ mail _____
(Please provide a self-addressed, stamped envelope for mailing)