9525 Katy Freeway, Suite 312
Houston, TX 77024
Tel: (713) 463-9449 Fax: (713) 463-7181

Refill Request Form

Date: _____/_____/_____

Patient Name: _____

DOB: _____ Patient Tel: _____

Address: _____

_____

Pharmacy: _____

Pharmacy Tel: _____ Pharmacy Fax: _____

Medication name and strength: _____

Directions:_____

Last Fill Date: _____/_____/_____

Medication name and strength: _____

Directions:_____

Last Fill Date: _____/_____/_____

Medication name and strength: _____

Directions:_____

Last Fill Date: _____/_____/_____

How would you like to receive your request?: ☐Office pick up ☐Mail ☐Send electronically

There is a $10 fee per prescription refill request of Schedule II medications between appointments. (Fee does not apply to Medicaid patients) Allow 72 hours processing time. A staff will contact you once your request has been processed. Thank you.