Child & Family Psychological Services, Inc.
Integrated Behavioral Associates

Person completing form: _____

Date: _____ **E-mail address:** _____

What office location do you use? ☐ Norwood ☐ Holliston ☐ Weymouth ☐ Quincy ☐ Abington

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Prescribing Clinician: ☐ **Lum** ☐ **Cashman** ☐ **Rifenburg** ☐ **Romanoff-Rand** ☐ **Pottanat**
☐ **Fish** ☐ **Zenker Daly**

Patient's Name: _____ **DOB:** _____

Last Appt. Date: _____ **Next Appt. Date:** _____ (must have scheduled appt. in order to receive refill)

Medication #1 (exact medication name on bottle): _____ ◯ 30-day refill
Dosage: _____ ◯ 60-day refill
Current Directions (e.g. – Take 1 tablet each morning): ◯ 90-day refill

_____

Medication #2 (exact medication name on bottle): _____ ◯ 30-day refill
Dosage: _____ ◯ 60-day refill
Current Directions ◯ 90-day refill

_____

Medication #3 (exact medication name on bottle): _____ ◯ 30-day refill
Dosage: _____ ◯ 60-day refill
Current Directions ◯ 90-day refill

_____

Requesting prescription to be: ☐ mailed ☐ left at reception for pick up ☐ sent electronically to pharmacy*

*All medications can now be sent electronically to most pharmacies and this is the preferred method for renewing prescriptions.

If to be mailed, mailing address: _____
If to be sent electronically, Pharmacy Name: _____
City Where Pharmacy Located (and street if more than 1 in town): _____

Print Form

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Also in Abington, Boston, Holliston, Newton, & Quincy