Louisville Pulmonary Care
Medication Refill Request

This form is encrypted to protect your privacy. Please fill in all blanks before submitting. It is our policy to require yearly office visits for ongoing medication prescriptions. If it has been more than a year since your last office visit, please make an appointment to see your physician. Please allow 48 hours for processing of your refill request. Refill requests made after 3 PM may not be processed until the next business day.

Submit Form

Refill Request Form

General Data

Patient Name _____ _____ _____
First Name Last Name MI

Date of Birth: □□ - □□ - □□□□
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Contact Phone Number: □□□-□□□-□□□□
eg - 5 0 2 X X X X X X X

My LPC Doctor is: --------- Select One ---------

Pharmacy name: _____

Pharmacy Phone Number: □□□-□□□-□□□□
eg - 5 0 2 X X X X X X X

Medication Allergies: _____
(write NIL if no allergies)

Medication refills requested:

Medication Name	Strength i.e. (MG/MCG/ML)	Dosage i.e. no. of puffs/tablets	Frequency of Dosage	PRN only as needed	No. of days for each refill	No. of refills (1-12)
			---- Select One ----	☐		
			---- Select One ----	☐		
			---- Select One ----	☐		
			---- Select One ----	☐		

Submit Form