

ADHD Med Refill

Sonja Brownlee MD - 778-6762, FAX 778-6767

Caller's Name _____ Today's Date & Time _____

Pt. Name _____ Phone Number(s): _____

Pt. DOB _____ Pt's School & Grade _____

Medication & Dose: amount (mg) & SPECIFIC time of day **Takes on weekends?** YES NO

Needs Rx: 1. _____ Also takes: 1. _____
2. _____ 2. _____
3. _____ 3. _____

Pharmacy? _____ Insurance: Medicaid Other None

HOW IS YOUR CHILD DOING ON HIS/HER MEDICATION?

Mornings: Hard to get out of bed? YES NO Eats breakfast? YES NO

Irritable: argues, struggles excessively? YES NO Has difficulty getting ready for school? YES NO

Comments: _____

School: Does the medication wear off at or during school? YES NO If so, by what time? _____

Grades:	Improving	The same	Worsening
Completing school work during class?	Improving	The same	Worsening
Follows instructions and/or rules?	Improving	The same	Worsening
Daydreaming, distracted?	Improving	The same	Worsening
Organizational skills?	Improving	The same	Worsening
Relationship with peers?	Improving	The same	Worsening

Teacher/Parent comments? _____

Afternoons/evenings: When does the medication wear off? _____

Rate the following problems that may occur at home: Not at all Just a little Pretty much Very much

Has difficulty completing homework?	_____	_____	_____	_____
Irritable, moody and/or argumentative?	_____	_____	_____	_____
Is easily distracted?	_____	_____	_____	_____
Difficulty getting to bed at bedtime?	_____	_____	_____	_____
Difficulty falling asleep?	_____	_____	_____	_____

If so, how long does it take to fall asleep _____ What helps him/her fall asleep? _____

Waking up during the night? Yes___ No___ If yes, how often? _____ Trouble fallings back to sleep? _____

Comments: _____

Has your child experienced any of the following side effects or problems in the last month?

- ___ Headache
- ___ Stomach ache/nausea
- ___ Are you concerned about your child's weight loss? YES NO
- ___ Dull, tired, listless behavior
- ___ Socially withdrawn - decreased interaction with others
- ___ Seems dazed or "like a zombie" or "robotic"
- ___ Repetitive movements, tics, jerking, twitching, eye blinking
- ___ Picking at skin or fingers, nail biting, lip or cheek chewing
- ___ Dizziness
- ___ Decreased appetite
- ___ Tremors/feeling shaky
- ___ Increased appetite
- ___ Extreme sadness or unusual crying
- ___ Sees or hears things that aren't there
- ___ Other problems:

Would you like to talk to the doctor about any concerns? YES NO