Allegro PEDIATRICS

Medication Form Completion Request

Patient Name: _____ Patient Date of Birth:_____

Parent/guardian section filled out on physical or medication form: ☐ Yes (if no, please complete)

Would you like to (check one):

☐ Receive form through the Patient Portal. Forms will be returned via the portal within 2 business days, M-F.

Please select one of the following:

☐ I have a portal account

☐ I need to set up a portal account

☐ Pick up form from clinic. Forms will be completed within 2 business days, M-F. Please provide the best phone number to call when ready for pick-up): _____

Comments? _____

For medication authorization forms, please also fill out the section below:

Medication Name: _____ Check one: ☐ Pill ☐ Liquid ☐ Chewable ☐ Other

Current weight (if known): _____ Reason for medication: _____

Strength of medication (e.g., “mg each” or “mg per ml”): _____

Dose (leave blank if unknown): _____

The patient is in: ☐ Elementary School ☐ Middle School ☐ High School

If patient is in Middle or High School, are they able to self-carry and self-administer this medication? ☐ Yes ☐ No

Medication refill needed? ☐ Yes ☐ No If Yes, what is your preferred pharmacy? _____

Medication Name: _____ Check one: ☐ Pill ☐ Liquid ☐ Chewable ☐ Other

Current weight (if known): _____ Reason for medication: _____

Strength of medication (e.g., “mg each” or “mg per ml”): _____

Dose (leave blank if unknown): _____

The patient is in: ☐ Elementary School ☐ Middle School ☐ High School

If patient is in Middle or High School, are they able to self-carry and self-administer this medication? ☐ Yes ☐ No

Medication refill needed? ☐ Yes ☐ No If Yes, what is your preferred pharmacy? _____

For additional medications, use the back of this form.

********** **Office Use Only** **********

Patient account #: _____ Today’s date: _____ (Due back w/in 48 hrs.)

Date of last WCC: _____

Preferred Provider (or last WCC provider): _____

Assigned to: _____ Check: ☐ PCP ☐ Practice Partner ☐ Other

Additional Medications:

Medication Name: ______________________________ Check one: ☐ Pill ☐ Liquid ☐ Chewable ☐ Other
Current weight (if known): ____________ Reason for medication: _____________________________________
Strength of medication (e.g., “mg each” or “mg per ml”): _____________________
Dose (leave blank if unknown): _____________________
The patient is in: ☐ Elementary School ☐ Middle School ☐ High School
If patient is in Middle or High School, are they able to self-carry and self-administer this medication? ☐ Yes ☐ No
Medication refill needed? ☐ Yes ☐ No If Yes, what is your preferred pharmacy? ________________________

Medication Name: ______________________________ Check one: ☐ Pill ☐ Liquid ☐ Chewable ☐ Other
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Medication refill needed? ☐ Yes ☐ No If Yes, what is your preferred pharmacy? ________________________

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Medication refill needed? ☐ Yes ☐ No If Yes, what is your preferred pharmacy? ________________________

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