

**SOUTHERN NEW HAMPSHIRE
INTERNAL MEDICINE ASSOCIATES**

PRESCRIPTION REFILL REQUEST

DATE: _____ PHYSICIAN: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

HOME NUMBER: _____

WORK/CELL NUMBER: _____

You may request up to 4 refills

<u>MEDICATION NAME</u>	<u>DOSE (mg)</u>	<u>QUANTITY</u>
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1.

2.

3.

4.

PHARMACY NAME: _____

LOCATION: _____

PHONE NUMBER: _____

(include area code)

***PLEASE ALLOW 48 HOURS
FOR THIS REQUEST TO BE PROCESSED
EXCLUDING WEEKENDS***

Fax to (603) 216-3800
Monday – Friday 730a-530p