



# INTERMOUNTAIN PET HOSPITAL

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## PRESCRIPTION REFILL REQUEST

Please fill out this form and we will fill your prescription(s). Please allow 24 hours to complete the refill request. If we have any questions or are having problems filling your prescription, we will call you at the phone number that you provide below.

### Client and Patient Information

Date: \_\_\_\_\_

Your Name: \_\_\_\_\_

E-mail: \_\_\_\_\_

Your Pet's

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

### Prescription Refills Requested

	Medication Requested	Dosage Size/Strength	Quantity Requested
Drug 1:			
Drug 2:			
Drug 3:			
Drug 4:			

### Your Pet's Current Medications

Please list the names and amounts of all medication that your pet is currently taking. Also, please include the approximate time of the last dose that your pet received of each medication.

	Medication Requested	Dosage Size/Strength	Quantity Requested
Drug 1:			
Drug 2:			
Drug 3:			
Drug 4:			
Drug 6:			

### Progress Report

Please identify whether you have experienced any of the following issues with your pet. When possible, please describe when you first noticed the problem, how often it occurs, whether it has occurred before, and any other details that you can provide:

Behavioral Changes \_\_\_\_\_

Vomiting and/or Diarrhea \_\_\_\_\_

Constipation \_\_\_\_\_

Coughing and/or Sneezing \_\_\_\_\_

Changes in Urination \_\_\_\_\_

Stiffness of Lameness \_\_\_\_\_

Other \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_