

Green Hills Pediatric Associates

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Nashville, TN 37205
(615) 385-1451, Fax (615) 298-4257

Over the Counter Medication Request Form

One week prior to needing your prescription, mail this form and a self-addressed stamped envelope to Green Hills Pediatric Associates.
The prescription will be written and mailed within 2 business days of receiving the request.
You may also fax or drop off this form for pick-up 2 business days later.
We will not write prescriptions for cold medicines for children under age 2 years.

Today's Date: _____ Patient's Doctor: _____

Patient's Name: _____ Birth Date: _____

Parent's Name: _____ Phone #: (H) _____ (C) _____

Medications: BE VERY SPECIFIC!

Medication #1

Type : Liquid
Chewable Pill
Pill
Other _____

Strength/Dose: _____

Frequency: _____

Quantity: _____

Diagnosis: _____

Medication #2

Type : Liquid
Chewable Pill
Pill
Other _____

Strength/Dose: _____

Frequency: _____

Quantity: _____

Diagnosis: _____

- I have included a self-addressed stamped envelope. Please mail the prescription to me.
- I would prefer to pick up the prescription at the office. Date: _____ Time: _____
- I faxed the form and would like to pick up the prescription at the office. Date: _____ Time: _____

For Office Use

Prescription filled: _____
Date Nurse Initials

Prescription delivered: faxed mailed will pick up