

North State Medical Group, PA

Refill Request

Patient Name: _____

Patient Date of birth: _____

Medication Name	Strength	Dosage
1. _____		
2. _____		
3. _____		

Date of last office visit: _____ Date of last labs: _____

Pharmacy Name: _____

Phone Number: _____ Fax number: _____

Additional Information:

Please check the location that you come to and fax/email it to us:

2266 North Highway 16
Denver, NC 28037
704-483-2200
Fax: 704-483-2214

9816 Sam Furr Road Suite 101
Huntersville, NC 28078
704-892-0335
Fax: 704-483-2214

501 North Aspen Street
Lincolnton, NC 28092
704-735-3116
Fax: 704-735-5713