



METROPOLITAN VETERINARY ASSOCIATES  
&  
EMERGENCY SERVICES

**Prescription Refill Request Form**

Client Name \_\_\_\_\_ Pet's Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone number(s) where you can be reached \_\_\_\_\_

Fax \_\_\_\_\_

**Choose a Department:**

- Cardiology
- Critical Care/Emergency Services
- Dentistry
- Dermatology
- Internal Medicine
- Neurology
- Ophthalmology
- Radiology
- Surgery

**Medication(s) Requested:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

- Medication will be picked up on (date) \_\_\_\_\_
- Please call into my pharmacy (phone number) \_\_\_\_\_

Please allow 24 hours for refills to be processed.

Most medications can be picked up Monday through Friday 8:00am to 6:00pm.

We will call you if your prescription cannot be filled.

**Please fax this form to 610-666-1199**

