☒ **Urgent** ☒ **Reply ASAP**

| | |
|---|---|
| To: | From: |
| RE Patient: | Date: |
| Phone Number: | Sender's Phone Number: |
| Fax Number: | Sender's Fax Number: |

## Pages Including Cover: 2

**---Patient Information Sheet---**
**PLEASE COMPLETE AND FAX BACK ASAP TO:**

**Date of Last Visit:** _____

**Reason for Visit:** _____

_____

**Allergies:** _____

_____

**Current Medications:** _____

_____

_____

**Affected Area:** _____

_____

Please remember to circle quantity and refill amount for the attached RX your patient has requested from our company.

**PAT ID #:**

Fax back to:

Prescription Request

Fax:

Date:

Refills RequestedAuthorized: 3

We request authorization on behalf of your patient

DOB:

Phone:

Patient:

**INFLAMMATION MANAGEMENT**

**Medication:** Diflorasone Diacetate Ointment 0.05%
**Dispense:** 180 Grams
**Sig:** Apply 1-2 gms to affected area(s) 2-3 times daily (1 gm =1 dime size).

**ORAL MUSCLE RELAXANT**

**Medication:** Cyclobenzaprine 5mg Tablet
**Dispense:** 90 Tablets
**Sig:** Take one tablet by mouth up to 3 times daily as need muscle spasm.

**HEART HEALTHY SUPPLEMENT (90 Day Supply)**

**Medication:** Omega-3 Acid Ethyl Esters
**Dispense:** 360 Capsules
**Sig:** Take one capsule four times a day.

Signature: _____ Date: _____

Doctor:

NPI:

Phone: Fax:

Dispense as Written: ☒

Notes: