

Urgent

Reply ASAP

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

Pages Including Cover: 2

<p style="text-align: center;">---Patient Information Sheet--- PLEASE COMPLETE AND FAX BACK ASAP TO:</p> <p>Date of Last Visit: _____</p> <p>Reason for Visit: _____</p> <p>_____</p> <p>Allergies: _____</p> <p>_____</p> <p>Current Medications: _____</p> <p>_____</p> <p>_____</p> <p>Affected Area: _____</p> <p>_____</p> <p>Please remember to circle quantity and refill amount for the attached RX your patient has requested from our company.</p> <table border="1" style="width: 100%;"><tr><td style="text-align: right;">PAT ID #:</td></tr></table>	PAT ID #:
PAT ID #:	

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Prescription Request

Fax:

Date:

Refills Requested Authorized: 3

We request authorization on behalf of
your patient

DOB:

Phone:

Please fax or call this request to:

Fax:

Patient:

INFLAMMATION MANAGEMENT

Medication: Diflorasone Diacetate Ointment 0.05%

Dispense: 360 Grams

Sig: Apply 2-3 gms to affected area(s) 3-4 times daily (1 gm = 1 dime size).

-OR-

Medication: Clobetasol 0.05% Ointment

Dispense: 360 Grams

Sig: Apply 2-3 grams to affected area(s) 3-4 times daily.

ORAL NSAID

Medication: Ketoprofen 25 mg Capsule

Dispense: 180 Capsules

Sig: Take 1-2 capsules by mouth up to 3 times daily.

ORAL MUSCLE RELAXANT

Medication: Cyclobenzaprine 7.5mg Tablet

Dispense: 120 Tablets

Sig: Take one tablet by mouth up to 4 times daily as need muscle spasm.

Signature: _____ Date: _____

Doctor:

NPI:

Phone:

Fax:

Dispense as Written:

Notes:

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