

**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;"><b>---Patient Information Sheet---</b> <b>PLEASE COMPLETE AND FAX BACK ASAP TO:</b></p> <p><b>Date of Last Visit:</b> _____</p> <p><b>Reason for Visit:</b> _____</p> <p>_____</p> <p><b>Allergies:</b> _____</p> <p>_____</p> <p><b>Current Medications:</b> _____</p> <p>_____</p> <p>_____</p> <p><b>Affected Area:</b> _____</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="width: 80%;"></td><td style="width: 20%;"><b>PAT ID #:</b></td></tr></table>			<b>PAT ID #:</b>
	<b>PAT ID #:</b>		

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Prescription Request

Fax:

Date:

Refills Requested Authorized: 3

We request authorization on behalf of  
your patient

DOB:

Phone:

Patient:

**ORAL NSAID**

**Medication:** Ketoprofen 25 mg Capsule

**Dispense:** 180 Capsules

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor:

NPI:

Phone:

Fax:

Dispense as Written:

Notes:

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Prescription Request

Fax:

Date:

Refills Requested Authorized: 3

We request authorization on behalf of  
your patient

DOB:

Phone:

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).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor:

NPI:

Phone:

Fax:

Dispense as Written:

Notes:

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Date:

Refills Requested Authorized: 3

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your patient

DOB:

Phone:

Patient:

**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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Prescription Request

Fax:

Date:

Refills Requested Authorized: 3

We request authorization on behalf of  
your patient

DOB:

Phone:

Patient:

**DIETARY 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:

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