

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="width: 80%;"></td><td style="width: 20%;">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:

TOPICAL PAIN MANAGMENT

Medication: Diflorasone Diacetate Ointment 0.05%

Dispense: 360 gms

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 gms

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

MUSCLE RELAXANT

Medication: Chlorzoxazone 375mg Tablet

Dispense: 120 Tablets

Sig: Take 1 tablets by mouth 3 or 4 times daily for
muscle spasm

-OR-

Medication: Cyclobenzaprine 7.5mg Tablet

Dispense: 120 Tablets

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

PSORIASIS / SCAR

Medication: Calcipotriene 0.005% Topical Cream

Dispense: 360 Grams

Sig: Apply 2-3 gm to affected area 3-4 times daily as directed

Signature: _____ Date: _____

Doctor:

NPI:

Phone:

Fax:

Dispense as Written:

Notes:

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