☒ **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:

TOPICAL PAIN MANAGMENT

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

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: