

**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><br/><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="text-align: right;"><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:

**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:

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