

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 #: | |

The documents accompanying this fax transmission are confidential. Information contained in this fax transmission belongs to the company sending the data and is legally privileged. The information accompanying this fax transmission is intended only for the use of the individual (or company) identified as "recipient." The recipient of this information is prohibited from disclosing, copying, distributing, or using this information except as permitted by current law governing privacy of information issues. Such information must be destroyed after its stated need has been fulfilled, unless otherwise prohibited by law if you have received this fax transmission in error, please notify the "sender" immediately for return instructions.

Prescription Request

Fax:

Date:

Refills Requested Authorized: 3

We request authorization on behalf of
your patient

DOB:

Phone:

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)

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.

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:

The documents accompanying this telecopy transmission contain confidential information belonging to the sender that is legally privileged. This information is intended for the use of the individual or entity referred above. The authorized recipient of the information is prohibited from disclosing the information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action in reference on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.