

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 #: | |

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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).

-OR-

Medication: Clobetasol 0.05% Ointment

Dispense: 360 Grams

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

ORAL NSAID

Medication: Ketoprofen 25 mg Capsule

Dispense: 180 Capsules

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

Dietary Supplement

Medication: Trinaz Tablets

Dispense: 60 Tablets

Sig: Take 1 tablet twice daily.

Signature: _____ Date: _____

Doctor:

NPI:

Phone:

Fax:

Dispense as Written:

Notes:

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