☒ **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: Cyclobenzaprine 7.5mg Tablet
Dispense: 120 Tablets
Sig: Take one tablet by mouth up to 4 times daily as need muscle spasm.

ACID REFFLUX

Medication:Omeprazole Sodium Bicarbonate (40mg/1100mg)
Dispense: 30 Capsules
Sig: Take one tablet by mouth up once daily on an empty stomach 1 hour before meal.

ANTI-FUNGAL

Medication: Econazole 1% Cream
Dispense: 340 gms
Sig: Apply 3-6 grams to affected area(s) three times daily (1gm = 1 dime size).

Signature: _____ Date: _____

Doctor:

NPI:

Phone: Fax:

Dispense as Written: ☒

Notes: