

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:

TOPICAL PAIN MANAGMENT

Medication: : Clobetasol 0.05% Ointment

Dispense: 3666470 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: Econazole 1% Cream

Dispense: 340 Grams

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:

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