☒ **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 #:

Rx Form PLEASE COMPLETE AND SEND TO PHARMACY

Patient Name:_____ **DOB:**_____ **Prescriber/Supervising Physician:**_____

Street Address:_____ **NPI:**_____ **DEA:**_____

City/State/Zip:_____ **Phone:**_____ **Email:**_____

Phone:_____ **Email:**_____ **Address:**_____

Allergies: NKDA **City/State/Zip:**_____

Medications: None indicated **Phone:**_____ **Fax:**_____

PAIN MANAGEMENT: LOCAL ANESTHETIC (SELECT 1)

☐ **Lidocaine 7% Tetracaine 7% Cream** (1 gram = 1 dime size) Qty: 300 gms Refills:_____ Default: 3
Sig: Apply a thin layer (2-3 gms) to affected area 3-4 times a day. Peel off after waiting the required application time as directed (max application time of 60 minutes).

☐ **Lidocaine 5% Ointment** Sig: Apply 2-3 gms to affected area(s) 3-4 times a day. (1 gram = 1 dime size). Qty: 300 gms Refills:_____ Default: 3

☐ **Lidocaine 2.5% Prilocaine 2.5% Cream** Sig: Apply 2-3 grams to the affected area 3-4 times daily. Qty: 360 gms Refills:_____ Default: 3

PAIN MANAGEMENT: NEUROPATHIC PAIN (SELECT 1)

☐ **Doxepin 5% Cream** Sig: Apply a thin film (1-2 gms) to painful area 3 times daily. Wait at least 3-4 hours between applications. (1 gram = 1 dime size) Qty 180 gms Refills:_____ Default: 3

INFLAMMATION MANAGEMENT: NON-STEROIDAL (SELECT 1)

☐ **Diclofenac 3% Topical Gel** Sig: Apply 2-3 gms to affected area(s) 3-4 times a day (1gram = 1 dime size). Qty 300 gms Refills:_____ Default: 3

INFLAMMATION MANAGEMENT: STEROID (SELECT 1)

☐ **Diflorasone Diacetate Ointment 0.05%** Sig: Apply 2-3 gms to affected area(s) 3-4 times daily (1 gm = 1 dime size). Qty: 360 gms Refills:_____ Default: 3

☐ **Hydrocortisone Butyrate Lotion 0.1%** Sig: Apply 4 mls to the affected skin area 2 times daily, and rub in gently. Qty: 236 MLS Refills:_____ Default: 3

☐ **Fluocinonide 0.1% Topical Cream** Sig: Apply 1-2 gm to affected area 3-4 times daily as directed. Qty: 240 gms Refills:_____ Default: 3

☐ **Clobetasol 0.05% Ointment** Sig: Apply 2-3 grams to affected area(s) 3-4 times daily. Qty: 360 gms Refills:_____ Default: 3

☐ **Desoximetasone 0.05% Cream** Sig: Apply 2-3 grams to affected area(s) 3-4 times daily. Qty: 360 gms Refills:_____ Default: 3

☐ **Triamcinolone Acetonide 0.147 mg/gm Topical Aerosol** Sig:Apply 2-3 sprays to affected area(s) 3-4 times daily (2 second spray = 1 gram). Qty: 400 gms Refills:_____ Default: 3

ORAL NSAID (SELECT 1)

☐ **Fenoprofen 200mg Capsule** Sig: Take 1-2 capsules by mouth up to 3 times daily. Qty 180 Caps Refills:_____ Default: 3

☐ **Ketoprofen 25 mg Capsule** Sig: Take 1-2 capsules by mouth up to 3 times daily. Qty 180 Caps Refills:_____ Default: 3

☐ **Naproxen Oral Suspenion (125MG/5ML)** Sig: Take 10-20ml by mouth twice daily as needed for pain. Qty 946 ML Refills:_____ Default: 3

☐ **Naproxen CR 375 mg** Sig: Take 1 tablet by mouth twice daily for pain. Qty 60 Tabs Refills:_____ Default: 3

ORAL MUSCLE RELAXANT (SELECT 1)

☐ **Chlorzoxazone 250mg Tablet** Sig: Take 1 tablet by mouth 3-4 times daily as needed for muscle spasm. Qty: 120 Tabs Refills:_____ Default: 3

☐ **Cyclobenzaprine 7.5mg Tablet** Sig: Take one tablet by mouth up to 4 times daily as need muscle spasm. Qty: 120 Tabs Refills:_____ Default: 3

☐ **Metaxalone 800mg Tablet** Sig: Take 1 tablet by mouth 3-4 times daily. Qty: 120 Tabs Refills:_____ Default: 3

SKIN EMOLLIENT (SELECT 1)

☐ **Kamdoy Rx Skin Emulsion** Sig: Apply daily 3-4 ML to affected area(s) twice daily. Qty: 240 MLS Refills:_____ Default: 3

PSORIASIS / SCAR (SELECT 1)

☐ **Calcipotriene 0.005% Topical Cream** Sig: Apply 2-3 gm to affected area 3-4 times daily as directed. Qty: 360 gms Refills:_____ Default: 3

☐ **Sil-K** Sig: Cut pad to fit scar with 1/4 inch beyond the scar on all sides. Apply patch and leave on for 8-12 hours per day then remove (Discard the pad and replace with a new one every 7 days) Qty 4 Patches Refills:_____ Default: 3

SUPPLEMENTS - NUTRIENT REPLACEMENT

☐ **Folika-D** Sig: Take 1 tablet by mouth once or twice daily as directed. Qty: 60 Tablets Refills:_____ Default: 3

SUPPLEMENTS - MICROBIOTA/GUT FLORA

☐ **Prodigen** Sig: Take 1 capsule by mouth twice daily as directed or optimum colonization of GI tract. Qty: 60 Capsules Refills:_____ Default: 3

ACID REFUX / PEPTIC ULCER / GERD

☐ **Omeprazole Sodium Bicarbonate (40mg/1100mg)** Sig: Take one capsule by mouth once daily on an empty stomach at least 1 hour before a meal. Qty: 300 Qty: 30 Caps Refills:_____ Default: 3

☒ **I authorize the Pharmacist in Charge (PIC) to substitute the product prescribed with an alternative formula or product under the same therapeutic class heading on this prescription if the patient does not have insurance, has a high deductible or copay,or has an insurance policy that does not cover the particular medication that I have prescribed. I understand that the purpose of this agreement is to provide each patient with an affordable option within the same scope as the initially-prescribed medication.**

☒ **I authorize this patient's medication to be automatically refilled at the patient's request.**

Prescriber's Signature_____ **Date**_____