Woodland Hills Compounding Pharmacy

AESTHETICS ORDER FORM

Phone: (855) 876-3060 | Fax: (866)893-9320

PATIENT INFORMATION

PATIENT NAME (PRINT) _____ DOB _____

ALLERGIES _____ PHONE _____

PATIENT ADDRESS _____

CITY STATE ZIP _____

PRODUCT	SIZE	REFILLS
Peel and Bleach Creams		
☐ Hydroquinone 6%, Retinoic Acid 0.05%, Hydrocortisone 0.5% Cream	☐ 30gm ☐ 60gm	_____
☐ Hydroquinone 8%, Retinoic Acid 0.1%, Hydrocortisone 0.5% Cream	☐ 30gm ☐ 60gm	_____
☐ Hydroquinone 6%, Kojic Acid 4%, Retinoic Acid 0.05%, Hydrocortisone 0.5%Cream	☐ 30gm ☐ 60gm	_____
SIG: Apply to dark patches 1-2 times a day		
Hydroquinone Creams		
☐ Hydroquinone 6% Cream	☐ 30gm ☐ 60gm	_____
☐ Hydroquinone 8% Cream	☐ 30gm ☐ 60gm	_____
☐ Hydroquinone 10% Cream	☐ 30gm ☐ 60gm	_____
SIG: Apply to dark patches 1-2 times a day		
Melasma Peel (Mask)		
☐ Azelaic Acid 15%, Hydroquinone 8%, Kojic Acid 4%, Retinoic Acid 0.1% Cream	☐ 30gm	_____
SIG: Apply mask for 8-12 hours, then wash off.		
☐ **Melasma Kit (4 Part)**		_____
• Melasma Peel (Mask) *Azelaic Acid 15%, Hydroquinone 8%, Kojic Acid 4%, Retinoic Acid 0.1% Cream*	30gm	
• Maintenance Cream *Hydroquinone 6%, Kojic Acid 4%, Retinoic Acid 0.05%, Hydrocortisone 0.5% Cream*	30gm	
• Clear Face Pads *Salicylic Acid, Sulfacetamide Sodium, Clindamycin*	100 pads	
• Peptide Cream *Hyaluronic Acid 1%, Argireline 5%, DMAE 3%, Ascorbic Acid 5% Cream*	30gm	
SIG: Use as directed		
Peptide Cream		
☐ Hyaluronic Acid 1%, Argireline 5%, DMAE 3%, Ascorbic Acid 5% Cream	☐ 30gm	_____
SIG: Apply under eyes & face every morning		
Face Pads		
☐ Clear Face Pads — *Salicylic Acid 2%, Sulfacetamide Sodium 5%, Clindamycin 1%, Astrigent Pad*	100 pads	_____
☐ Daily Facial Peel — *Glycolic Acid 1%, Salicylic Acid 1%, Lactic Acid 3%*	100 pads	_____
☐ Weekly Facial Peel — *Glycolic Acid 2%, Salicylic Acid 2%, Lactic Acid 4%*	100 pads	_____
☐ Ultra Complexion Pads — *Glycolic Acid 10%, Salicylic Acid 5%*	100 pads	_____
☐ Mild Lightening Pads — *Hydroquinone 2%, Kojic Acid 4%, Salicylic Acid 2%*	100 pads	_____
☐ Skin Lightening Pads — *Hydroquinone 4%, Kojic Acid 4%*	100 pads	_____
SIG: Use as directed		

Physician Verification

I have reviewed my patient's medical record and determined the medication(s) / supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me.

Signature: _____ Date: _____

Physician: _____ NPI #: _____

Address: _____ City: _____ ST: ____ Zip: _____

Phone: _____ Fax: _____

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Revision Date: 09/23/2016