PRESCRIPTION

ADDITIONAL MENTAL HEALTH OFFERINGS FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME: DATE of BIRTH (Month / Day)

_____/_____

PRIMARY PHONE #: ◯ CELL ◯ HOME ◯ WORK SECONDARY PHONE #: ◯ CELL ◯ HOME ◯ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

RETAIL PRODUCTS (can be compounded for allergy and dose purpose)

☐ Fluoxetine ◯ Tablet ◯ Capsule ◯ 10mg ◯ 20mg ◯ 40mg ◯ 60mg ◯ 90mg

☐ Sertraline ◯ 25mg ◯ 50mg ◯ 100mg

☐ Citalopram ◯ 10mg ◯ 30mg ◯ 40mg

☐ Escitalopram ◯ 5mg ◯ 10mg ◯ 20mg

☐ Bupropion ◯ IR ◯ ER ◯ 75mg ◯ 150mg ◯ 300mg

☐ Venlafaxine ◯ IR ◯ ER ◯ 37.5mg ◯ 75mg ◯ 150mg

☐ Paroxitine ◯ IR ◯ CR ◯ 10mg ◯ 12.5mg ◯ 20mg ◯ 37.5mg ◯ 40mg

☐ Duloxetine ◯ 20mg ◯ 30mg ◯ 60mg

SUPPORT OFFERINGS

☐ Zofran Tablet ODT ◯ 4mg ◯ 8mg

☐ Phenergan ◯ 12.5mg ◯ 25mg ◯ 50mg

☐ TransdermScope 1mg/3day ◯ #4 ◯ #10 ◯ #24

☐ Sirolimus IR 6mg

Refills: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ PRN ◯ NR SIG:_____

WRITE PRESCRIPTION / ADDITIONAL COMMENTS

DOCTOR PHONE NPI # DEA #

OFFICE MANAGER PHONE OFFICE FAX OFFICE Email

SIGNATURE DATE (Month / Day / Year)

_____/_____/_____