PRESCRIPTION

CHELATION FIXED ORDER 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:

☐ **DMSA - Urine Challenge Test**	◯ 200 mg	Take 2 capsules prior to urine collection
	◯ 500 mg	◯ Take 1 capsule prior to urine collection
		◯ Take 3 capsules prior to urine collection
		◯ Take 4 capsules prior to urine collection
☐ **DMSA - Heavy Metal Treatment Protocols**	◯ 10 mg/kg	Days 1-5: Take 3 times daily. Days 6-20: Take twice daily. (Repeat course in 2 weeks)
	◯ _____ mg	_____ doses/day for _____ day(s) (Repeat course every _____ days).
☐ **EDTA - Heavy Metal Treatment Protocols**	◯ _____ mg	_____ doses per day.

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)

_____/_____/_____