PRESCRIPTION

ENT 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:

MEDICATIONS

☐ Amitriptyline / Gabapentin / Lidocaine - Oral Rinse	2% / 6% / 0.5%	◯ 150 ml ◯ _____
☐ Betahistine - Capsule	◯ 8mg ◯ 16mg ◯ 24mg	◯ 30 ◯ 60 ◯ 120 ◯ _____
☐ Budesonide Viscous - Oral Solution	◯ 0.5mg / 10ml ◯ 1mg / 10ml ◯ 2mg / 20ml	◯ 150 ml ◯ _____
☐ Doxepin - Mouthwash	0.5%	◯ 150 ml ◯ _____
☐ Lidocaine - Oral Spray	4%	◯ 15 ml ◯ _____
☐ Menthol - Oral Solution	0.3%	◯ 15 ml ◯ _____
☐ Tetracaine - Oral Spray	0.5%	◯ 15 ml ◯ _____

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)

_____/_____/_____