PRESCRIPTION

LDN 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:

COMPOUNDED LOW DOSE NALTREXONE

☐ **LDN 1.5mg Capsule**

◯ Sig: Take 1 Capsule Daily at Bedtime for 2 Weeks, then 2 Capsules Daily at Bedtime for 2 Weeks, then 3 Capsules Daily at Bedtime for 2 Weeks.

◯ Take 1 Capsule Daily at Bedtime

Dispense ◯ 30 ◯ 60 ◯ 90 _____

☐ **LDN 3mg Capsule**

Sig: Take 1 Capsule by mouth Daily at Bedtime.

Dispense ◯ 30 ◯ 60 ◯ 90 _____

☐ **LDN 4.5mg Capsule**

Sig: Take 1 Capsule by Mouth Daily at Bedtime.

Dispense ◯ 30 ◯ 60 ◯ 90 _____

** Standard Microcrystalline Cellulose Filler, Veggie Dye Free Capsules unless other option requested.*

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)

_____/_____/_____