PRESCRIPTION

MESO THERAPHY 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:

COMMON LOXASPERSE CAP

☐ Aminophylline (not comp)		25 mg/ml	◯ 10	◯ 20 ml
☐ Ascorbic Acid		500 mg/ml		50 ml
☐ Biotin		0.5 mg/ml		20 ml
☐ BLT Cream	◯ 20%/6%/4%	◯ 20%/10%/4%		120 gm
☐ BLT Solution		(20%/6%/4%)		30 ml
☐ Carnitine (L) NP	◯ 100 mg/ml	◯ 500mg/ml		30 ml
☐ Collagenase		1,000 units/ml		10 ml
☐ Glutathione	◯ 100 mg/ml	◯ 200 mg/ml		10 ml
☐ Hylenex (hyaluronidase SDV)		150 units/ml		4×1 ml
☐ Ketoralac (SDV)		30 mg/ml		1 ml
☐ Lidocaine (MDV)		◯ 1% ◯ 2%		50 ml
☐ Lipoic Acid		25 mg/ml		30 ml
☐ Methylcobalamin		10 mg/ml		10 ml
☐ Meyers Infusion Bag (Banana Bag)				100 ml
☐ Meyers Infusion Vial				30 ml
☐ M.I.C.		25/50/50 mg/ml		30 ml
☐ M.I.C. w/B12		25/50/50/1 mg/ml		30 ml
☐ Multi-Vitamin (not compounded)		Box of 5×10ml		50 ml
☐ Multi-Trace Elements		25ml		25 ml
☐ Phenoxybenzamine / Dexamethasone	◯ 5mg/0.5ml	◯ 5mg/1.0ml ◯ 5mg / 1.5ml		10 ml
☐ Phosphatidyl / DC		(50 / 42) mg/ml clear	◯ 10 ◯ 30 ◯ 50	◯ 100 ml
☐ Phosphatidyl / DC		(100 / 84) mg/ml clear		30 ml
☐ Phosphatidyl / DC		(100 / 60) mg/ml clear	◯ 30	◯ 100 ml
☐ Procaine NP		◯ 1% ◯ 2%		30 ml
☐ Pyridoxine		100 mg/ml		30 ml
☐ Vitrase (Hyaluronidase)		200 units/ml		2×1.2 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)

_____/_____/_____