PRESCRIPTION

NASAL SPRAY FIXED

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:

NASAL SPRAY

☐ Ampho B 0.06%

Quantity _____

SIG: Instill 1 Spray Each Nostrils _____ Daily

☐ BEG

Quantity _____

SIG: Instill 1 Spray Alternating Nostrils _____ Daily

☐ BEGI

Quantity _____

SIG: Instill 1 Spray Alternating Nostrils _____ Daily

☐ EDTA / Itraconazole in Colloidal Silver

Quantity _____

SIG: Instill 1 Spray Alternating Nostrils _____ Daily

☐ EDTA in Colloidal Silver

Quantity _____

SIG: Instill 1 Spray Alternating Nostrils _____ Daily

☐ Fluconazole 0.75%

Quantity _____

SIG: Instill 1 Spray Each Nostrils _____ Daily

☐ Glutathione 6%

Quantity _____

SIG: Instill 1 Spray Each Nostrils _____ Daily

☐ Nystatin 50,000u/Spray

Quantity _____

SIG: Instill 1 Spray Each Nostrils _____ Daily

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)

_____/_____/_____