PRESCRIPTION

RECTAL CREAMS 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

☐ Diltiazem	◯ 2% or	◯ ____%	Cream	◯ 30gm	◯ 60gm
☐ Diltiazem / Lidocaine	◯ 2% / 1% or	◯ ____% / ____%	Cream	◯ 30gm	◯ 60gm
☐ Nifedipine	◯ 0.2% or	◯ ____%	Ointment	◯ 30gm	◯ 60gm
☐ Nifedipine / Lidocaine	◯ 0.2% / 1% or	◯ ____% / ____%	Ointment	◯ 30gm	◯ 60gm
☐ Nitroglycerin	◯ 0.3% or	◯ ____%	Ointment	◯ 30gm	◯ 60gm
☐ Nitroglycerin / Lidocaine	◯ 0.3% / 1% or	◯ ____% / ____%	Ointment	◯ 30gm	◯ 60gm

SIG (Applies to all options)

Apply a pea sized amount ____ times daily rectally as directed.

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)

_____/_____/_____