PRESCRIPTION

SPORTS MEDICINE 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:

SPORTS MEDICINE

☐ Aluminum Chlorohydrate 5%	Topical Powder	◯ 1oz / ◯ 2oz / ◯ 4oz / _____ oz
☐ Diclofenac Sodium 10%	Topical Cream	◯ 1oz / ◯ 2oz / ◯ 4oz / _____ oz
☐ Flurbiprofen 10% / Baclofen 2% / Cyclobenzaprine 2% / Tetracaine 2%	Topical Cream	◯ 1oz / ◯ 2oz / ◯ 4oz / _____ oz
☐ Flurbiprofen 10% / Cyclobenzaprine 1% / Gabapentin 6% / Lidocaine 2% / Prilocaine 2%	Topical Cream	◯ 1oz / ◯ 2oz / ◯ 4oz / _____ oz
☐ Glutathione 20%	Topical Cream	◯ 1oz / ◯ 2oz / ◯ 4oz / _____ oz
☐ Itraconazole 1% / Ibuprofen 2% / DMSO	Nail Solution	◯ 1oz / ◯ 2oz / ◯ 4oz / _____ oz
☐ Ketoprofen 10% / Tizanidine 0.2% / Bupivacaine 1%	Topical Cream	◯ 1oz / ◯ 2oz / ◯ 4oz / _____ oz
☐ Magnesium Sulfate Heptahydrate 10%	Topical Cream	◯ 1oz / ◯ 2oz / ◯ 4oz / _____ oz
☐ Tea Tree Oil 5.4% / Lavender Oil 1% / Clotrimazole 1% / Undecylenic Acid 5% / Urea 5%	Topical Cream	◯ 1oz / ◯ 2oz / ◯ 4oz / _____ oz

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)

_____/_____/_____