PRESCRIPTION

TEST DOSE 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 (Mixture)

☐ Prostaglandin PGE1 ◯ 10µg ◯ 20µg ◯ 40µg ◯ 50µg

☐ Bimix A Papaverine 30mg / Phentolamine 1mg

☐ Trimix Mayo Std. Papaverine 18mg / Phentolamine 0.6mg / PGE1 5.88µg

☐ Trimix 2 Papaverine 30mg / Phentolamine 0.5mg / PGE1 20µg

☐ Quadrimix Papaverine 30mg / Phentolamine 2mg / PGE1 20µg / Atropine 0.1

DISPENSE

☐ Test Dose 1.0ml vial

Sig:

- Inject intracavernosally as instructed in office by physician.
- Refills: _____

1cc = 100 units

SYRINGES

☐ Insulin syringes U-100 (short needle: 1cc; 30 gauge × 1/2")

☐ Insulin syringes U-100 (Short needle: 1cc; 31 gauge × 5/16")

CUSTOM REQUESTS OR INSTRUCTIONS

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)

_____/_____/_____