PRESCRIPTION

UROLOGY 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

☐ Alprostadil	◯ 20 ◯ 40 mcg/ml	◯ 5ml ◯ 10ml
☐ Bimix (Papaverine/Phentolamine)	30mg / 0.5mg/ml	◯ 5ml ◯ 10ml
☐ Bimix A (Papaverine/Phentolamine)	30mg / 1mg/ml	◯ 5ml ◯ 10ml
☐ Custom Bimix (Papaverine/Phentolamine)	_____mg / _____g/ml	◯ 5ml ◯ 10ml
☐ Trimix Mayo : Standard (Papaverine/Phentolamine/Alprostadil)	18mg / 0.6mg / 5.88mcg/ml	◯ 5ml ◯ 10ml
☐ Trimix Mayo : Double (Papaverine/Phentolamine/Alprostadil)	18mg / 0.6mg / 11.8mcg/ml	◯ 5ml ◯ 10ml
☐ Trimix Mayo : Super (Papaverine/Phentolamine/Alprostadil)	18mg / 0.6mg / 30mcg/ml	◯ 5ml ◯ 10ml
☐ Trimix I (Papaverine/Phentolamine/Alprostadil)	30mcg / 0.5mg / 10mcg/ml	◯ 5ml ◯ 10ml
☐ Trimix II (Papaverine/Phentolamine/Alprostadil)	30mg / 0.5mg / 20mcg/ml	◯ 5ml ◯ 10ml
☐ Trimix IA (Papaverine/Phentolamine/Alprostadil)	30mg / 1mg / 10mcg/ml	◯ 5ml ◯ 10ml
☐ Trimix IB (Papaverine/Phentolamine/Alprostadil)	30mg / 1mg / 20mcg/ml	◯ 5ml ◯ 10ml
☐ Custom Trimix (Papaverine/Phentolamine/Alprostadil)	_____mg / _____mg / _____mcg/ml	◯ 5ml ◯ 10ml
☐ Quadmix I (Papaverine/Phentolamine/Alprostadil/Atropine)	9mg / 1mg / 10mcg / 0.1mg/ml	◯ 5ml ◯ 10ml
☐ Quadmix II (Papaverine/Phentolamine/Alprostadil/Atropine)	9mg / 1mg / 20mcg / 0.1mg/ml	◯ 5ml ◯ 10ml
☐ Custom Quadmix (Papaverine/Phentolamine/Alprostadil/Atropine)	____mg / ____mg / ____mcg / ____mg/ml	◯ 5ml ◯ 10ml
☐ Syringes 1cc, 31G, 5/16"		_____ # (Pack of 10)
☐ Syringes 1/2cc, 31G, 5/16"		_____ # (Pack of 10)
☐ Syringes 3/10cc, 31G, 5/16"		_____ # (Pack of 10)
☐ Sudafed		_____ # (Box of 24)
☐ Sildenafil	◯ 20mg ◯ 25mg ◯ 50mg ◯ 100mg Tabs.	_____ Qty.
☐ Tadalafil	◯ 5mg ◯ 10mg ◯ 20mg Tabs.	_____ Qty.
☐ Tadalafil 4mg / Maca Root 300mg / ◯ With ◯ Without Vitamin D3 1000 iu Capsules (Compounded)		_____ Qty.
☐ Tadalafil 23mg / Maca Root 300mg / ◯ With ◯ Without Vitamin D3 1000 iu Capsules (Compounded)		_____ Qty.
☐ Clomiphene Citrate	50mg Tabs	_____ Qty.
☐ Sildenafil	100mg RDT	_____ Qty.
☐ Tadalafil	22mg RDT	_____ Qty.
☐ Muse Suppository	◯ 125mg ◯ 250mg ◯ 500mg ◯ 1000mg # 6 Suppositories	

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)

_____/_____/_____