

MD Office Information

Fax to 949-551-1950

(This Rx Pad is printed on Request of Physician)

Patient Name: (First)	(Last)	Parents:	
Address:	City:	State:	Zip:
Date of Birth:	Home Ph:	Cell Ph:	Work Ph:
Patient's Height:	Patient's Weight:	Allergies	
Insurance:	ID#	Ph#	PLEASE ATTACH CARD COPY!

Name of compounded medication	Dosage form	Instructions	QTY	Refills
Methylcobalamin P-F Dose _____ mcg	Injection Nasal Spray Lippo-Gel			
Glutathione Transdermal or Nebulized _____mg/dose	Lippo-Gel Inhalation			
Nystatin Suspension CF, GF, SF, DF, AF Dose _____units/_____ml	Suspension or Veggie Caps			
Fluconazole Suspension CF, GF, SF, DF, AF Dose _____mg/_____ml	Suspension or Veggie Caps			
Valcyclovir Suspension CF, GF, SF, DF, AF Dose _____mg/_____ml	Suspension or Veggie Caps			
Metronidazole Suspension CF, GF, SF, DF, AF Dose _____mg/_____ml	Suspension Or Veggie Caps			
DMPS or DMSA Dose _____mg (Circle one please)	Caps or Suppos or Transdermal			
Naltrexone Transdermal _____mg/dose	Lippo-Gel			
EDTA Suppository Dose _____mg	Suppository			
EMLA Cream (circle one please) EMLA DS Cream	Cream			
Other				

Physician's Signature (Do Not Substitute)

Date

MD Address
MD Phone and Fax