

# Veterinarian Information

**Fax to 949-551-1950**

(This Rx Pad is printed on Request of Physician)

Patient Name: (First) _____	(Last) _____	Parents: _____
Address: _____	City: _____	State: _____ Zip: _____
Medication Allergies: _____	Home Ph: _____	Cell Ph: _____ Work Ph: _____

Name of compounded medication	Dosage form	Instructions	QTY	Refills
Potassium Bromide _____mg	Liquid or Capsules			
Sodium Bromide _____mg	Liquid or Capsules			
Methimazole _____mg	TD Ear Gel or Liquid			
Prednisolone Acetate _____mg	Liquid or Capsule			
Metronidazole _____mg	Liquid or Capsule			
Prednisone _____mg	Liquid or Capsule			
Ursodiol _____mg	Liquid or Capsule			
Phenoxybenzamine _____mg	Liquid or Capsule			
Cyclosporine (A) _____mg	Liquid or Capsule			
Cyclosporine (A) _____% Ophth	Soln Ointment			
Tacrolimus _____% Ophth	Soln Ointment			
Calcitriol _____nanogram	Liquid Capsule			
Amlodipine _____mg	TD Ear Gel or Liquid			
Diltiazem _____mg	Liquid TD Ear Gel DR Capsule			
Piroxicam _____mg	Capsule or Liquid			
Cisapride _____mg	Capsule or Liquid			
Mitotane _____mg	Capsule or Liquid			
Lomustine _____mg	Capsule			
Other				

\_\_\_\_\_  
**Veterinarian Signature** (Do Not Substitute)  
 Address:  
 Contact:

\_\_\_\_\_  
**Date**  
 Phone:  
 Fax: