National Pharmacy

PATIENT

NAME:	STREET:	
DOB:		
PHONE:	CITY:	
EMAIL:	STATE:	ZIP:
ALLERGIES:		

FORMULATION

☐ Tetracaine HCL (Pontocaine) ☐ 240mL

☐ 2% ☐ 4% ☐ 6%

☐ Theophylline 0.5% Nasal Spray ☐ 30mL

☐ Sinusitis Nasal Spray ☐ 30mL
Mupirocin 0.2%, Itraconazole 1%, Xylitol 2%,
Bismuth 0.1%, Triamcinolone 0.03%

☐ CSF Otic Capsules ☐ _____ Capsules
Chloramphenicol 50mg, Sulfamethoxazole 50mg, Amphotericin 5mg

Dispensed with Sheehy-house insufflator.

☐ Mastoid-HC Otic Capsules: Ciprofloxacin 50mg, Clotrimazole 50mg, Boric Acid 50mg, Hydrocortisone 1mg ☐ _____ Capsules

Dispensed with Sheehy-house insufflator.

☐ Other:

PRESCRIBER

NAME:	STREET:	
PHONE:		
FAX:	CITY:	
EMAIL:	STATE:	ZIP:

STATE LICENSE #:	DEA #:	NPI #:

SIGNATURE: _____ DATE: _____

FAX PRESCRIPTION TO:
(323) 851-4445