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Pain - Inflammation/Neuropathic Prescription Form

PATIENT INFORMATION:

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Birth Date: _____

Allergies: _____ e-mail Address: _____

PHYSICIAN INFORMATION:

Physician Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ e-mail Address: _____

NSAIDS: (Pain & Inflammation)

Ketoprofen	5%	10%	15%
Diclofenac	3%	5%	10%
Ibuprofen	10%	20%	
Piroxicam	1%		

Skeletal Muscle Spasms:

Cyclobenzaprine	1%	2%
Guaifenesin	5%	10%

Anesthetic:

Lidocaine	1%	2%	5%
Tetracaine	2%	4%	
Bupivacaine	0.5%	1%	

Neuropathy:

Amitriptyline	1%	2%	
Ketamine	1%	2%	5%
Gabapentin	3%	6%	
Clonidine	0.1%	0.2%	0.3%
Baclofen	1%	2%	
Carbamazepine	1%	2%	

(Circle desired ingredients & strengths, or write your own formula for the above compounds)

Quantity: (Check the Quantity for the above compound)

___ 30 gm ___ 60 gm ___ 120 gm

Directions:

REFILL _____ TIMES

D.E.A.: _____ Physician's Signature: _____