

Inland Compounding Pharmacy, Inc. 24747 Redlands Blvd., Suite F, Loma Linda, CA 92354
Phone: 909 478-3842 Fax: 909 478-3853

Wound Care 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: _____

(Circle desired ingredients & strengths)

Antibiotic:

Metronidazole 1% 2%

Growth Stimulator:

Phenytoin 0.2% 1% 2%
Misoprostol 0.002%

Anesthetic :

Tetracaine 2% 4%
Lidocaine 1% 2.5% 5%
Bupivacaine

Circulation:

Nifedipine 0.2% 1% 4%

(Choose one of the following Bases and Quantity for the above compounds)

___ Gel – for dry or tunneling wounds _____ 15 gm
___ Emollient – for decubitus wounds, very hydrating _____ 30 gm
___ Polyox – for high draining wounds _____ Other

Directions:

REFILL _____ TIMES

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