



Sterile Prescription Order Form

Fax Order To: 800-556-5893

PATIENT INFORMATION: For Office Use For Veterinary Use 1.) FL, NY, & NV: No "Office Use" Permitted.
2.) Controlled substances may no longer be ordered for Office Use. (Except Testosterone Pellets & Aqueous Testosterone Suspension.)

Male / Female

Patient Name Sex Date of Birth Date

Patient Address (No PO Boxes)

City State Zip

Phone (H) (W) (Cell) Email

Diagnosis (Required for Controlled Substances) Allergies

PRESCRIPTION:

Drug Strength Vial Size Quantity

Directions (please include dose and frequency) Preserved or Pres-Free* Refills

Circle Appropriate Route of Administration(s): IV IM SQ ID (Intradermal- Antigens/Mesotherapy) Prolotherapy

*Please Note: Any preservative-free vial sent to a patient **MUST BE A SINGLE-DOSE VIAL** or **BE ACCOMPANIED BY A LETTER** from the prescribing practitioner stating that the patient is trained and competent in sterile technique.

PRACTITIONER INFORMATION: Circle Designation: MD DO PA NP ND DDS DVM DPM

Practitioner Name (Please Print) Signature (Required)

DEA# License# Phone Fax

Office Address (if first time ordering) City/State/Zip

Contact Person (if further information is required) / Faxed By:

Delivery Address (if different from patient or practitioner address) City/State/Zip

Place Office Address Stamp Here.
(Signature Still REQUIRED.)

BILLING INFORMATION:

Bill the following Credit Card: Visa/MC/AMX OR Bill Credit Card On File.

Name on Card: _____ Last 4 #'s On CC: _____

CC#: _____ Security Code: _____

Exp. Date: _____ Security Code: _____