



FAX Cover Sheet

From: _____

Date: _____

Fax #: _____

Phone #: _____

To: Mixtures Pharmacy

Fax: 480-706-0489

Ahwatukee (Phone: 480-706-0620)

Gilbert (Phone: 480-300-5279)

Scottsdale (Phone: 480-400-0649)

Subject: New Rx

Pages: (including the cover sheet) # _____

Comments:

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Patient Name: _____ DOB: ____/____/____
 Address: _____ City _____ State _____ Zip _____
 Phone: (____) _____ - _____ Allergies: _____

| | Medication/Dose (<input type="checkbox"/> Check box(es) of ingredients desired and include the %) | Directions |
|-----------------|---|---|
| NSAID | <input type="checkbox"/> Diclofenac(DF) (2-10%) _____ % <input type="checkbox"/> Ketoprofen(KP) (5-10%) _____ % <input type="checkbox"/> Ibuprofen(IBU) (20%) _____ % <input type="checkbox"/> Piroxicam(PRX) (2%) _____ % | <input type="checkbox"/> Apply to the affected area three to four times daily as needed. <input type="checkbox"/> |
| NUMB ING | <input type="checkbox"/> Bupivacaine(BPV) (1%) _____ % <input type="checkbox"/> Prilocaine(PLC) (2%) _____ % <input type="checkbox"/> Lidocaine(LDC) (5-10%) _____ % <input type="checkbox"/> Tetracaine (TTC) (2%) _____ % | |
| MISC | <input type="checkbox"/> Amitriptyline(AMIT) (2-10%) _____ % (Sympatholytic/NE reuptake inhibitor) <input type="checkbox"/> Imipramine(IMP) (3%) _____ % (NE Reuptake Inhibitor) <input type="checkbox"/> Baclofen(BAC) (2%) _____ % (Muscle Relaxant) <input type="checkbox"/> K_____ (KTM) _____ % (5-10%)(NMDA-Ca++ channel blocker) (*must write Ketamine) <input type="checkbox"/> Carbamazepine(CZP) _____ % (3-10%) (NMDA Na+ blocker/Muscle Relaxant - not 1st line choice) <input type="checkbox"/> Nifedipine(NFP) (2%) _____ % (Non-NMDA L-type calcium channel blocker & vasodilator) <input type="checkbox"/> Cyclobenzaprine(CBP) _____ % (2%) (Muscle Relaxant - 2nd line therapy) <input type="checkbox"/> Pentoxifylline(PTX) (3%) _____ % (TNF-1a inhibitor) <input type="checkbox"/> DMSO (1-5%) _____ % (Driving agent) <input type="checkbox"/> Magnesium(MG) (10%) _____ % (NMDA-Ca++ channel blocker) <input type="checkbox"/> Gabapentin(GAB) _____ % (6-10%) (AMPA-Na+ channel blockers) | Supply <input type="checkbox"/> 30gm <input type="checkbox"/> 60gm <input type="checkbox"/> 120gm Refills |

| Medication/Dose (*Must write controlled substance in order to be in rx) | Directions |
|--|--|
| <input type="checkbox"/> K_____ (KTM) (10%)/ AMIT/LDC/MG/PLC _____ %/2/6/10/2/5/2% (*must write Ketamine) <input type="checkbox"/> K_____ (KTM) (12%)/ AMIT/LDC/MG/PLC _____ %/4/6/10/2/5/2% (*must write Ketamine) | <input type="checkbox"/> Apply to the affected area three to four times daily as needed. <input type="checkbox"/> |
| <input type="checkbox"/> K_____ (KTM) (10%)/ BAC/GAB/IMP/NFP/TTC _____ %/2/6/3/2/2% (*must write Ketamine) | |
| <input type="checkbox"/> K_____ (KTM) (10%)/ BPV/CLN/DXP/GAB/PTX/TRM _____ %/1/0.2/5/6/3/3% (*must write Ketamine) | Supply <input type="checkbox"/> 30gm <input type="checkbox"/> 60gm <input type="checkbox"/> 120gm |
| <input type="checkbox"/> K_____ (KTM) (2-5%)/ KP/BPV/DMSO _____ %/5/1/5% (*must write Ketamine) | Refills |
| <input type="checkbox"/> K_____ (KTM) (10%)/ KP _____ %/10% (*must write Ketamine) | |

| | | | | |
|--------------------------------------|------------|-------|----------------|--------------|
| Signature (Substitution Permissible) | Print Name | DEA # | Office Phone # | Date written |
|--------------------------------------|------------|-------|----------------|--------------|

Abbreviations

| | |
|------|-----------------|
| AMIT | Amitriptyline |
| BAC | Baclofen |
| BPV | Bupivacaine |
| CBP | Cyclobenzaprine |
| CLN | Clonidine |
| CZP | Carbamazepine |
| DF | Diclofenac |
| GAB | Gabapentin |
| IBU | Ibuprofen |
| IMP | Imipramine |
| KP | Ketoprofen |
| KTM | Ketamine |
| LDC | Lidocaine |
| MG | Magnesium |
| NFP | Nifedipine |
| PLC | Prilocaine |
| PRX | Piroxicam |
| PTX | Pentoxifylline |
| TRM | Tramadol |
| TTC | Tetracaine |