



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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Pet's Name: _____ /Owner _____ DOB: _____ / _____ / _____
 Address: _____ City _____ State _____ Zip _____
 Phone: (____) _____ - _____ Allergies: _____

	Medication/Dose	Directions	Supply	Refills
F L U C O N A Z O L E	Fluconazole <input type="checkbox"/> _____ mg capsule	Give 1 capsule <input type="checkbox"/> once <input type="checkbox"/> twice daily	<input type="checkbox"/> #60 <input type="checkbox"/> #120 <input type="checkbox"/> #180 <input type="checkbox"/> __capsule	
	Formulary strengths of compounded Fluconazole <input type="checkbox"/> 25mg <input type="checkbox"/> 40mg <input type="checkbox"/> 250mg <input type="checkbox"/> 400mg	Give 1 capsule <input type="checkbox"/> once <input type="checkbox"/> twice daily	<input type="checkbox"/> #120 capsule	
	Fluconazole (commercially available: not compounded) <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <input type="checkbox"/> 150mg <input type="checkbox"/> 200mg	Give 1 capsule <input type="checkbox"/> once <input type="checkbox"/> twice daily	<input type="checkbox"/> #60 <input type="checkbox"/> #120 <input type="checkbox"/> #180 <input type="checkbox"/> __capsule	
	Fluconazole <input type="checkbox"/> _____ mg/ml suspension	Give _____ ml <input type="checkbox"/> once <input type="checkbox"/> twice daily	<input type="checkbox"/> #30ml <input type="checkbox"/> #60ml <input type="checkbox"/> #90ml <input type="checkbox"/> __ml	

	Medication/Dose	Directions	Supply	Refills
M a i n t e n a n c e	Methimazole Anhydrous Transdermal <input type="checkbox"/> 2.5mg/0.1ml(2 clicks) <input type="checkbox"/> 5mg/0.1ml <input type="checkbox"/> 10mg/0.1ml <input type="checkbox"/> _____ mg/ _____ ml	Apply <input type="checkbox"/> 1(0.05ml) <input type="checkbox"/> 2(0.1ml) click(s) to inner ear pinna <input type="checkbox"/> daily <input type="checkbox"/> bid alternating ears	<input type="checkbox"/> 3ml <input type="checkbox"/> 6ml	
	Methimazole Anhydrous Suspension <input type="checkbox"/> _____ mg/ml	Give _____ ml <input type="checkbox"/> qd <input type="checkbox"/> bid	<input type="checkbox"/> __ml	
	Fluoxetine <input type="checkbox"/> _____ mg capsule <input type="checkbox"/> _____ mg/ml anhydrous suspension <input type="checkbox"/> _____ mg/0.1ml(2 clicks) transdermal gel	<input type="checkbox"/> Give 1 capsule daily <input type="checkbox"/> Give 1ml daily <input type="checkbox"/> Apply 2 clicks (0.1ml) to inner ear daily	<input type="checkbox"/> #__ <input type="checkbox"/> __ml <input type="checkbox"/> 3 <input type="checkbox"/> 6ml	
	Levetiracetam <input type="checkbox"/> _____ mg capsule <input type="checkbox"/> _____ mg/ml anhydrous suspension	<input type="checkbox"/> Give 1 capsule q12h <input type="checkbox"/> Give 0.5ml q12h	<input type="checkbox"/> #__ <input type="checkbox"/> __ml	
	Ursodiol <input type="checkbox"/> _____ mg capsule <input type="checkbox"/> _____ mg/ml suspension	<input type="checkbox"/> Give 1 capsule twice daily <input type="checkbox"/> Give _____ ml twice daily	<input type="checkbox"/> __cap <input type="checkbox"/> __ml	
	Trilostane <input type="checkbox"/> _____ mg capsule <input type="checkbox"/> _____ mg/ml suspension	<input type="checkbox"/> Give 1 capsule twice daily <input type="checkbox"/> Give _____ ml twice daily	<input type="checkbox"/> __cap <input type="checkbox"/> __ml	
	Pimobendan <input type="checkbox"/> _____ mg capsule <input type="checkbox"/> _____ mg/ml suspension	<input type="checkbox"/> Give 1 capsule twice daily (q12h) <input type="checkbox"/> Give _____ ml twice daily (q12h)	<input type="checkbox"/> __cap <input type="checkbox"/> __ml	

Signature (substitution permissible) | Printed Name | DEA (for Testosterone) | Office Phone # | Date

Pet's Name: _____ /Owner _____ DOB: _____ / _____ / _____

Address: _____ City _____ State _____ Zip _____

Phone: (____) _____ - _____ Allergies: _____

		Medication/Dose	Directions	Supply	Refills
A C U T E	B _____ <input type="checkbox"/> _____ mg capsule _____ <input type="checkbox"/> _____ mg/ml solution (*Must write Buprenorphine if intended to be in the prescription)	(may cause sedation) <input type="checkbox"/> Give 1 capsule every 8-12 hours prn pain <input type="checkbox"/> Give _____ ml every 8-12 hours prn pain	<input type="checkbox"/> __ cap <input type="checkbox"/> __ ml		
	Gabapentin <input type="checkbox"/> _____ mg capsule <input type="checkbox"/> _____ mg/ml anhydrous suspension	<input type="checkbox"/> Give 1 capsule twice daily <input type="checkbox"/> Give _____ ml twice daily	<input type="checkbox"/> __ cap <input type="checkbox"/> __ ml		
	Tylosin <input type="checkbox"/> _____ mg capsule <input type="checkbox"/> _____ mg/ml anhydrous suspension	<input type="checkbox"/> Give 1 capsule twice daily <input type="checkbox"/> Give _____ ml twice daily	<input type="checkbox"/> __ cap <input type="checkbox"/> __ ml		
	Prednisone <input type="checkbox"/> _____ mg capsule <input type="checkbox"/> _____ mg/ml suspension	<input type="checkbox"/> Give 1 capsule every _____ hours <input type="checkbox"/> Give _____ ml every _____ hours	<input type="checkbox"/> __ cap <input type="checkbox"/> __ ml		
	PrednisOLONE <input type="checkbox"/> _____ mg capsule <input type="checkbox"/> _____ mg/ml suspension	<input type="checkbox"/> Give 1 capsule every _____ hours <input type="checkbox"/> Give _____ ml every _____ hours	<input type="checkbox"/> __ cap <input type="checkbox"/> __ ml		

	Medication/Dose (<input type="checkbox"/> Check box(es) of desired ingredients & quantity)	Directions
Poloxamer Otic Gel	(Mast cell Stabilizer) <input type="checkbox"/> Tranilast 3% (Antifungal) <input type="checkbox"/> Ketoconazole <input type="checkbox"/> 1% <input type="checkbox"/> 2% (Steroid) <input type="checkbox"/> Betamethasone 1.2% <input type="checkbox"/> Hydrocortisone 1% <input type="checkbox"/> Triamcinolone <input type="checkbox"/> 0.1% <input type="checkbox"/> 0.5% (Antibiotic) <input type="checkbox"/> Azithromycin <input type="checkbox"/> 0.5% <input type="checkbox"/> 1% <input type="checkbox"/> 2% <input type="checkbox"/> Chloramphenicol 0.5% <input type="checkbox"/> Ciprofloxacin 2% <input type="checkbox"/> Enrofloxacin <input type="checkbox"/> 0.5% <input type="checkbox"/> 1% <input type="checkbox"/> 2% <input type="checkbox"/> Gentamicin 0.3% <input type="checkbox"/> Miconazole 1% <input type="checkbox"/> Mupirocin 2% <input type="checkbox"/> Vancomycin 25%	Bring to office for administration in ear canal <input type="checkbox"/> Dog: 3ml (1.5ml in each ear) <input type="checkbox"/> Cat: 1ml (0.25 - 0.5ml in each ear)
Topical Otic	<input type="checkbox"/> Tranilast 3% / Ketoconazole 2% / Triamcinolone 0.5%	<input type="checkbox"/> Apply to each ear twice daily for "cauliflower ear" for 30 days 15ml
	<input type="checkbox"/> Ivermectin 1% Cream	<input type="checkbox"/> Apply to each ear and repeat in 7 days for ear mites 3ml
Acral Lick Granuloma	<input type="checkbox"/> Diphenhydramine 2.5% Polyox Bandage	<input type="checkbox"/> Apply powder to the affected area as directed twice daily. 30gm

Signature (substitution permissible)

Printed Name

DEA (for Testosterone)

Office Phone #

Date