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:

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

Address:_____ City_____State_____Zip_____

Phone: (_____)_____-_____ Allergies:_____

	Medication/Dose	Directions	Supply	Refills
FLUCONAZOLE	**Fluconazole** ▢**_____mg capsule**	Give 1 capsule ▢ once ▢twice daily	▢#60 ▢#120 ▢#180 ▢___capsule	
	Formulary strengths of compounded Fluconazole ▢**25mg** ▢**40mg** ▢**250mg** ▢**400mg**	Give 1 capsule ▢ once ▢twice daily	▢#120 capsule	
	Fluconazole (commercially available: not compounded) ▢**50mg** ▢**100mg** ▢**150mg** ▢**200mg**	Give 1 capsule ▢ once ▢twice daily	▢#60 ▢#120 ▢#180 ▢___capsule	
	Fluconazole ▢**_____mg/ml suspension**	Give ____ml ▢once ▢twice daily	▢#30ml ▢#60ml ▢#90ml ▢___ml	

	Medication/Dose	Directions	Supply	Refills
Maintenance	**Methimazole Anhydrous Transdermal** ▢**2.5mg/0.1ml**(2 clicks) ▢**5mg/0.1ml** ▢**10mg/0.1ml** ▢**_____mg/____ml**	Apply ▢1(0.05ml) ▢2(0.1ml) click(s) to inner ear pinna ▢ daily ▢bid alternating ears	▢3ml ▢6ml	
	Methimazole Anhydrous Suspension ▢**____mg/ml**	Give _____ml ▢qd ▢bid	▢___ml	
	Fluoxetine ▢**_____mg capsule** ▢**_____mg/ml anhydrous suspension** ▢**_____mg/0.1ml**(2 clicks) **transdermal gel**	▢Give 1 capsule daily ▢Give 1ml daily ▢Apply 2 clicks (0.1ml) to inner ear daily	▢#___ ▢___ml ▢3▢6ml	
	Levetiracetam ▢**_____mg capsule** ▢**_____mg/ml anhydrous suspension**	▢Give 1 capsule q12h ▢Give 0.5ml q12h	▢#___ ▢___ml	
	Ursodiol ▢**_____mg capsule** ▢**_____mg/ml suspension**	▢ Give 1 capsule twice daily ▢ Give _____ml twice daily	▢___cap ▢____ml	
	Trilostane ▢**_____mg capsule** ▢**_____mg/ml suspension**	▢ Give 1 capsule twice daily ▢ Give _____ml twice daily	▢___cap ▢____ml	
	Pimobendan ▢**_____mg capsule** ▢**_____mg/ml suspension**	▢ Give 1 capsule twice daily (q12h) ▢ Give _____ml twice daily (q12h)	▢___cap ▢____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
ACUTE	**B_____** ▢**_____mg capsule** ▢**_____mg/ml solution** (*Must write Buprenorphine if intended to be in the prescription)	(may cause sedation) ▢ Give 1 capsule every 8-12 hours prn pain ▢ Give ___ml every 8-12 hours prn pain	▢___cap ▢____ml	
	Gabapentin ▢**_____mg capsule** ▢**_____mg/ml anhydrous suspension**	▢ Give 1 capsule twice daily ▢ Give _____ml twice daily	▢___cap ▢____ml	
	Tylosin ▢**_____mg capsule** ▢**_____mg/ml anhydrous suspension**	▢ Give 1 capsule twice daily ▢ Give _____ml twice daily	▢___cap ▢____ml	
	Prednisone ▢**_____mg capsule** ▢**_____mg/ml suspension**	▢ Give 1 capsule every _____hours ▢ Give _____ml every _____hours	▢___cap ▢____ml	
	PrednisOLONE ▢**_____mg capsule** ▢**_____mg/ml suspension**	▢ Give 1 capsule every _____hours ▢ Give _____ml every _____ hours	▢___cap ▢____ml	

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

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