

VIAL PRESCRIPTION TEMPLATE (NATIONAL)

Date Written: _____

*By law you may fill this prescription at any pharmacy of your choice.

Patient Name: Address: _____ Established Prescriber/Patient Relationship: <input type="checkbox"/>	Sex: M F D.O.B: _____ Phone: _____ Allergies: _____ Diagnosis: _____
Medical Facility: Address: _____	Contact Person: _____ Phone: _____
Prescribing Provider:	NPI #: _____ DEA #: _____

*All drugs on this prescription are to be compounded unless the commercial product is available.

Drug Name	Quantity	Refills	Day Supply	Dose	Route	Freq.
Amino Acids 50ml PFV						
Acetylcysteine 100mg/ml 50ml MDV						
Alpha Lipoic Acid 25mg/ml 10ml PFV						
Artemisinin 8mg/ml 30ml PFV						
Ascorbic/Taurine 500mg/20mg/ml 50ml PFV						
B Complex B1 10%/B5 5%/B3 5%/B6 5%/B2 2% 30ml MDV						
Biotin 10mg/ml 10ml MDV						
Carnitine-L 500mg/ml 10ml MDV						
Chloride Combo Forte (Ca 50mg/ml, Mg 200mg/ml, K 74.5mg/ml) 10ml MDV						
CoQ10 100mg/ml 10ml MDV						
Curcumin 20mg/ml 10ml PFV						
Dexpanthenol 250mg/ml 30ml MDV						
DMP5 50mg/ml 5ml MDV						
DMSO 80% 10ml PFV						
EDTA Calcium 300mg/ml 10ml MDV						
EGCG 10mg/ml 10ml MDV						
Glutathione 200mg/ml 30ml MDV						
Hydrogen Peroxide 3% 10ml MDV						
Hydroxocobalamin 5mg/ml 5ml MDV						
Lysine 100mg/ml 30ml MDV						
Magnesium Sulfate 25% 50ml MDV						
Melatonin 10mg/ml PFV						
Methylene Blue 10mg/ml 10ml MDV						
M.I.Carnitine. 25/50/50mg/ml 30ml MDV						
M.I.Carnitine. + B12 25/50/50/1mg/ml 30ml MDV						
NAD+ 50mg/ml 5ml PFV						
NAD+ 100mg/ml 10ml MDV						
Procaine 2% 30ml MDV						
Pyridoxine HCL/Thiamine 100mg/100mg/ml 30ml MDV						
Quercetin 20mg/ml 10ml PFV						
Resveratrol 25mg/ml 10ml PFV						
Selenium 200mcg/ml 10ml MDV						
Sermorelin SL 300mcg/ml 30ml						
Taurine 50mg/ml 10ml MDV						
Total Cobalamins 1mg/ml 30ml MDV						
Total Cobalamins 5mg/ml 30ml MDV						
Trace Elements 10ml PFV						
Vitamin D3 100,000iu/ml 10ml MDV						
Zinc Chloride 10mg/ml 10ml MDV						

Required: Reason for compound: _____

Pick up / Delivery

Ship to: Dr Pt Mon Tue Wed Thurs Fri Date: _____	Ship products as soon as they become available
Bill to: Dr Pt AM PM All Day Time: _____	Wait until all products are available before shipping

 Prescriber's Signature