

Veterinary Prescription Template

Patient	Client's Last Name	Client's First Name
	Pet's Name	Client's DOB _____ / _____ / _____
	Address	
	City	State
	Phone	Zip

Suspensions	<input type="checkbox"/> Buprenorphine 0.3ml/ml Solution	Give _____ ml every _____ hours	1 month	11 refills
	<input type="checkbox"/> Doxycycline 100mg/ml Suspension	Give _____ ml every _____ hours	1 month	11 refills
	<input type="checkbox"/> Fluoxetine 10mg/ml Suspension	Give _____ ml every _____ hours	1 month	11 refills
	<input type="checkbox"/> Gabapentin 100mg/ml Suspension	Give _____ ml every _____ hours	1 month	11 refills
	<input type="checkbox"/> Methimazole 5mg/ml Suspension	Give _____ ml every _____ hours	1 month	11 refills
	<input type="checkbox"/> Methimazole 10mg/ml Suspension	Give _____ ml every _____ hours	1 month	11 refills
	<input type="checkbox"/> Omeprazole 10mg/ml Suspension	Give _____ ml every _____ hours	1 month	11 refills
	<input type="checkbox"/> Prednisolone 10mg/ml Suspension	Give _____ ml every _____ hours	1 month	11 refills
	<input type="checkbox"/> Prednisolone 20mg/ml Suspension	Give _____ ml every _____ hours	1 month	11 refills
	<input type="checkbox"/> Other:	Give _____ ml every _____ hours	____ months	____ refills

Other Medication	<input type="checkbox"/> Budesonide Capsules	<input type="checkbox"/> 0.25mg <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg <input type="checkbox"/> 3mg <input type="checkbox"/> Other:	Give _____ capsule(s) every _____ hours	1 month	11 refills
	<input type="checkbox"/> Cisapride Capsules	<input type="checkbox"/> 5mg <input type="checkbox"/> 8mg <input type="checkbox"/> Other:	Give _____ capsule(s) every _____ hours	1 month	11 refills
	<input type="checkbox"/> DES Capsules	<input type="checkbox"/> 1mg <input type="checkbox"/> Other:	Give _____ capsule(s) once daily for _____ days then once weekly	1 month	11 refills
	<input type="checkbox"/> Gabapentin Soft Treat	<input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <input type="checkbox"/> Other:	Give _____ soft treat(s) every _____ hours	1 month	11 refills
	<input type="checkbox"/> Gabapentin Tiny Tab (T.T.)	<input type="checkbox"/> 50mg <input type="checkbox"/> Other:	Give _____ T.T. every _____ hours	1 month	11 refills
	<input type="checkbox"/> Methimazole Transdermal	<input type="checkbox"/> 2.5mg/0.1ml <input type="checkbox"/> 5mg/0.1ml <input type="checkbox"/> 10mg/0.1ml	Apply _____ ml every _____ hours. Wear gloves. Wash hands after use.	1 month	11 refills
	<input type="checkbox"/> Other:		Give _____ every _____ hours	____ months	____ refills

Prescriber	Name		
	Phone		
	Address		
	DEA/NPI		
	Signature		Date

Fax to Mix Pharmacy – 651-925-8659

Other: