

Allcare

PHARMACY & COMPOUNDING

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PATIENT INFORMATION

Patient Name: _____ DOB: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Male Female

DELIVERY DEVICE

Check one: Allcare Sinus Rinse Bottle
 NasoNeb Nasal Nebulizer
 Nasal Spray
 Nasal Gel
 Pluronic Nasal Drop

MEDICATION ALLERGIES

No Known Drug Allergies

NEW NASAL SPRAY

Azelastine 0.175% + Mometasone 0.06% Add Ketotifen 0.05%
SIG: Instill 1-2 sprays in each nostril twice daily
#24 mL (240 sprays) _____ Refills

TRY OUR NEW NASAL SPRAY!

TREATMENT OPTIONS

TREATMENT OPTIONS	FREQUENCY	DAYS SUPPLY	REFILLS
<input type="checkbox"/> Sulfamethoxazole 80mg/ Trimethoprim 50mg/ Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Ciprofloxacin 100mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Mupirocin 5mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Gentamicin 80mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Ceftriaxone 125mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Levofloxacin 100mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Levocetirizine 4mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Levofloxacin 100mg/Amphotericin B 5mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Tobramycin 125 mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Vancomycin 160 mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Vancomycin 160mg/Itraconazole 40mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Tobramycin 125 mg/Itraconazole 40mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Tobramycin 125mg/Amphotericin B 5mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Tobramycin 125mg/Mupirocin 5mg/Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> Other:		
<input type="checkbox"/> Tobramycin 125 mg/Vancomycin 160mg/Budesonide 0.5mg			

SINGLE MEDICATIONS

FREQUENCY

DAYS SUPPLY

REFILLS

ANTIBIOTICS

Sulfamethoxazole 80mg/ TMP 50mg BID OTHER:
 Ceftriaxone 125mg BID OTHER:
 Ciprofloxacin 125mg BID OTHER:
 Clindamycin 150mg BID OTHER:
 Gentamicin 80mg BID OTHER:
 Levofloxacin 100mg BID OTHER:
 Mupirocin 5mg BID OTHER:
 Tobramycin 125mg BID OTHER:
 Vancomycin 160mg BID OTHER:

ANTIFUNGALS

Amphotericin B 5mg BID OTHER:
 Fluconazole 15mg BID OTHER:
 Itraconazole 40mg BID OTHER:
 Ketoconazole 50mg BID OTHER:

SINGLE MEDICATIONS

FREQUENCY

DAYS SUPPLY

REFILLS

STEROIDS

Budesonide 0.5mg BID OTHER:
 Mometasone 0.6mg BID OTHER:
 Betamethasone 0.6mg BID OTHER:
 Clindamycin 150mg BID OTHER:

ANTIHISTAMINES AND OTHER

Levocetirizine 4mg BID OTHER:
 Loratadine 2mg BID OTHER:
 Acetylcysteine 200mg BID OTHER:
 Betahistine 8 mg oral capsules TID OTHER:

Allergy

Levocetirizine 5mg + Mometasone 0.6mg/mL Refills: _____
SIG: Use 1 spray in each nostril twice a day as directed

OTHER:

Mupirocin 2%/Clotrimazole 1%/Polysporin 25% ointment/Hydrocortisone 2%
Sig: Fill affected ear canal(s) with medication every 3 days for _____ weeks
of 5mL syringes Refills: _____

Custom Formulations:

PRESCRIBER NAME: _____ NPI: _____ DEA: _____
ADDRESS: _____
PHONE: _____ FAX: _____ SUPERVISING: _____
PRESCRIBER SIGNATURE: _____ DATE: _____
Subsidiary Pharmacia

I have reviewed my patient's medical record and determined the medication(s)/supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me. LEGAL NOTE: This fax transmission may contain confidential information belonging to the sender, which is legally privileged. This information is intended only for the use of the recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of any action or reliance on the contents of this faxed information is strictly prohibited. Drug Disclaimer: These products have not been approved by the FDA and have not been evaluated for safety or efficacy.