

Allcare

PHARMACY & COMPOUNDING

112 S Oxley Dr. Lyons, Ga 30436
Phone: 912-526-3206

FAX:
912-526-5960
866-892-9495

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

TREATMENT OPTIONS

		FREQUENCY	DAYS SUPPLY	REFILLS
A	<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:		
B	<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:		
C	<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:		
D	<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	<input type="checkbox"/> BID <input type="checkbox"/> Other:		

SINGLE MEDICATIONS

	SINGLE MEDICATIONS	FREQUENCY	DAYS SUPPLY	REFILLS	SINGLE MEDICATIONS	FREQUENCY	DAYS SUPPLY	REFILLS
E	ANTIBIOTICS				STERIODS			
	<input type="checkbox"/> Sulfamethoxazole 80mg/ TMP 50mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			<input type="checkbox"/> Budesonide 0.5mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:		
	<input type="checkbox"/> Mupirocin 5mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			<input type="checkbox"/> Mometasone 0.6mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:		
	<input type="checkbox"/> Ciprofloxacin 125mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			<input type="checkbox"/> Betamethasone 0.6mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:		
F	<input type="checkbox"/> Tobramycin 125mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			ANTIHISTAMINES AND OTHER			
	<input type="checkbox"/> Gentamicin 80mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			<input type="checkbox"/> Levocetirizine 4mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:		
	<input type="checkbox"/> Levofloxacin 100mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			<input type="checkbox"/> Acetylcysteine 200mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:		
	<input type="checkbox"/> Ceftriaxone 125mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			ORAL ANTIHISTAMINE <input type="checkbox"/> 8 mg <input type="checkbox"/> 24 mg	<input type="checkbox"/> TID <input type="checkbox"/> OTHER:		
	<input type="checkbox"/> Vancomycin 160mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			<input type="checkbox"/> Betahistine <input type="checkbox"/> 16 mg <input type="checkbox"/> 36 mg			
	<input type="checkbox"/> Clindamycin 150mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			Allergy			
	ANTIFUNGALS				<input type="checkbox"/> Levocetirizine 5mg + Mometasone 0.6mg/mL	Refills: _____		
	<input type="checkbox"/> Amphotericin B 5mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			SIG: Use 1 spray in each nostril twice a day as directed			
	<input type="checkbox"/> Fluconazole 15mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			OTHER:			
	<input type="checkbox"/> Itraconazole 40mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			<input type="checkbox"/> Mupirocin 2%/Clotrimazole 1%/Polysporin 25% ointment/Hydrocortisone 2%			
	<input type="checkbox"/> Ketoconazole 50mg	<input type="checkbox"/> BID <input type="checkbox"/> OTHER:			Sig: Fill affected ear canal(s) with medication every 3 days for _____ weeks			
					# of 5mL syringes Refills: _____			

OTIC TREATMENTS

	DIRECTIONS	REFILLS
<input type="checkbox"/> Ciprofloxacin 0.3% + Mometasone 0.1%	Apply 4-5 drops to the affected ear(s) twice daily for _____ days	<input type="checkbox"/> Chloramphenicol 50 mg, Sulfacetamide 50 mg and Amphotericin B 5 mg (CSF) <input type="checkbox"/> add Hydrocortisone 1mg SIG: Remove capsule top and place in Insufflator device. Use 1 puff to affected ear(s) twice daily after gentle cleaning with cotton tip applicator. QTY _____ REFILLS _____
<input type="checkbox"/> Fluocinolone 0.01% + Ketoconazole 1%		
<input type="checkbox"/> Ciprofloxacin 0.3% + Dexamethasone 0.1% + Clotrimazole 1%		

Custom Formulations:

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

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.