

PATIENT NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____

ALLERGIES: _____

Inflammation

Diclofenac 3% + Baclofen 2% + Cyclobenzaprine 2% + Lidocaine 2%

Qty: 60g 120g 240g _____ Refills: _____

SIG: Apply 1-2 grams topically to area of pain 3-4 times each day as needed

Diclofenac 4% + Lidocaine 5% + Gabapentin 10% + Baclofen 2% + _____

Qty: 60g 120g 240g _____ Refills: _____

SIG: Apply 1-2 grams topically to area of pain 3-4 times each day as needed

**If you wish to include Ketamine 5%
- please write it in here!**

Ketoprofen 20% + Baclofen 2% + Cyclobenzaprine 2% + Gabapentin 6% + Lidocaine 2.5%

Qty: 60g 120g 240g _____ Refills: _____

SIG: Apply 1-2 grams topically to area of pain 3-4 times each day as needed

Ketoprofen 20% + Baclofen 2% + Cyclobenzaprine 2% + Gabapentin 6% + Lidocaine 2.5% + _____

Qty: 60g 120g 240g _____ Refills: _____

SIG: Apply 1-2 grams topically to area of pain 3-4 times each day as needed

Ibuprofen 20%, Piroxicam 1% Cream

Qty: 60g 120g 240g _____ Refills: _____

SIG: Apply 1-2 grams topically to area of pain 3-4 times each day as needed

Muscle Spasms

Guaifenesin 10% + Magnesium Sulfate 10% Cream

Qty: 60g 120g 240g _____ Refills: _____

SIG: Apply 1-2 grams topically to area of pain 3-4 times each day as needed

Flurbiprofen 10%, Baclofen 2%, Cyclobenzaprine 2%, Tetracaine 2% Cream

Qty: 60g 120g 240g _____ Refills: _____

SIG: Apply 1-2 grams topically to area of pain 3-4 times each day as needed

Build your own!

Anti-Inflammatory

Diclofenac _____%

Ibuprofen _____%

Ketoprofen _____%

Neuropathic Pain

Gabapentin _____%

Amitriptyline _____%

Doxepin _____%

Clonidine _____%

Muscle Relaxant

Baclofen _____%

Guaifenesin _____%

Cyclobenzaprine _____%

Anesthetic

Lidocaine _____%

Prilocaine _____%

Tetracaine _____%

Bupivacaine _____%

NMDA Receptor Antagonist

_____ %

Magnesium _____%

Dextromethorphan _____%

Qty: 60g 120g 240g _____

Refills: _____

Sig: Apply 1-2 grams topically to area of pain 3-4 times each day as needed

PRESCRIBER NAME: _____ NPI: _____ DEA: _____

ADDRESS: _____

PHONE: _____ FAX: _____ SUPERVISING: _____

PRESCRIBER SIGNATURE: _____ DATE: _____ Refills: _____