JB Pharmacy Compound Prescription Request

Patient/Client Name_____ Date_____
Address:_____ DOB:_____
Contact Phone Number:_____ Allergies:_____

RX:

Please indicate all active pharmaceutical ingredients % concentration and preferred vehicle requirements (if any) in finished preparation

ACTIVE PHARMACEUTICAL INGREDIENTS: **CONCENTRATION / % AMOUNT**

INSTRUCTIONS FOR USE:

_____ **TOTAL AMOUNT OF FINISHED PREPARATION:**

_____ **REFILLS AUTHORIZED:**_____

SPECIAL CONSIDERATIONS/COMMENTS:

_____ _____
Prescriber Name *Address*

_____ _____
Prescriber Signature *Phone*

_____ _____
Date *Fax*

_____ _____
Dea Number *NPI Number*

Note: All prescriptions will be filled with cost effective generic equivalent ingredients unless otherwise indicated by prescriber.

FAX COMPLETED PRESCRIPTION REQUEST TO (401) 383-7773
Contact pharmacy at (401) 861-1194 for formulation information / recommendations