



Date: _____ Patient Name: _____
 DOB: _____ Address: _____
 City: _____ State: _____ Phone: _____ Allergies: _____
 Call When Ready Text Message When Ready Delivery Mail Out

Diphenhydramine HCl 1%/Dexamethasone Sodium Phosphate 0.05% Topical Gel (ZoSil™)

Qty: _____
 Sig: _____

Strength: _____
 Qty: _____
 Sig: _____

Refills: 1 2 3 4 5 PRN

Veterinary Healthcare Provider Signature:

Print Name: _____ Agent sending: _____

NPI: _____ DEA: _____

Clinic Name: _____
 Clinic Address: _____
 Clinic Phone/Fax: _____

