Date: ____________ **Patient Name**: ____
DOB: ______________**Address:** ____
City: _____________**State:** ______ **Phone:** ____________ **Allergies:** _________________

☐ **Call When Ready** ☐ **Text Message When Ready** ☐ **Delivery** ☐ **Mail Out**

☐ **Doxycycline Oil Oral Suspension**
Strength: ___________
Qty: ____________
Sig: ____

☐ **Tramadol HCl 50 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Metronidazole 25 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Theophylline 50 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Aminophylline 58.35 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Ursodiol 100 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Cisapride 10 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Sildenafil Citrate 10 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Itraconazole 150 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Chloramphenicol 250 mg/ml Oral Suspension**
Qty: ____________
Sig: ____

☐ **Tetracycline HCl 100 mg/ml Oral Suspension**
Qty: ____________
Sig: ____

☐ **Ciprofloxacin 50 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Hydrocodone 2 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Gabapentin 100 mg/ml Oral Suspension**
Qty: ____________
Sig: ____

☐ **Griseofulvin 25 mg/ml Oral Suspension**
Qty: ____________
Sig: ____

☐ **Famotidine 5 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Potassium Citrate 500 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Tranilast 20 mg/ml Oral Suspension**
Qty: ____________
Sig: ____

☐
Strength:_________
Qty: ____________
Sig: ____

____
Veterinary Healthcare Provider Signature:

Refills: 1 2 3 4 5 PRN

Print Name: ____________________________________ **Agent sending**: ____________________________
NPI: ____ **DEA**: ____________________________________

Clinic Name: ____
Clinic Address: _____________________________________
Clinic Phone/Fax: ___________________________________