Date: ___________ **Patient Name**: ____
DOB: _____________**Address:** ____
City: _____________**State:** ______ **Phone:** ____________ **Allergies:** _________________
☐ **Call When Ready** ☐ **Text Message When Ready** ☐ **Delivery** ☐ **Mail Out**

☐ **Ivermectin 0.1 mg/0.1 ml Topical Lipoderm®**
Qty: ____________
Sig: ____

☐ **Ivermectin 1 mg/ml Oil Oral Suspension**
Qty: ____________
Sig: ____

☐ **Ivermectin 1% 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: __________________________________