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

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

☐ **Magnesium Chloride Hexahydrate 10% Topical Lipoderm® Cream**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

☐ **Magnesium Chloride 10%/Peppermint 1% Topical Cream**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

☐ **Guaifenesin 10% Topical Lipoderm® Cream**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

☐ **Guaifenesin 10%/Magnesium Sulfate Heptahydrate 10% Topical Lipoderm® Cream**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

☐ **Ketoprofen 5%/Cyclobenzaprine HCl 0.5%/Lidocaine HCl 5%/Bupivacaine HCl 1% Topical Lipoderm® Cream**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

☐ **Flurbiprofen 10%/Baclofen 2%/Cyclobenzaprine HCl 2%/Tetracaine 2% Topical Lipoderm® ActiveMax™ Cream**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

☐ **Ketoprofen 10%/Cyclobenzaprine HCl 2% Topical Lipoderm® Cream**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

_______________________________________ **Refills:** **1** **2** **3** **4** **5** **PRN**
Healthcare Provider Signature:
Print Name: ____________________________________ **Agent sending**: _____________________________
NPI: ____ **DEA**: ____________________________________

Clinic Name: ______________________________________
Clinic Address: ____________________________________
Clinic Phone/Fax: __________________________________