**Date:** ____________ **Patient Name**: ________________________________________________
**DOB**: ______________**Address:** ______________________________________________________
**City:** ______________**State:** ______ **Phone:** _____________ **Allergies:** __________________

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

☐ **Boric Acid 600 mg Capsules**
Qty: 30 capsules or: _____________
Sig: Insert capsule vaginally as directed
or: _______________________________________________

☐ **Boric Acid 30% Vaginal Gel (MucoLox™)**
Qty: #30 gm or: other_____________
Sig: Use 1 gm vaginally as directed
or: _______________________________________________

☐ **Metronidazole 125 mg/ml/Nystatin 25,000 U/ml Vaginal Cream**
Qty: #30 gm, or: other_____________
Sig: Use 1 gm vaginally as directed
or: _______________________________________________

☐ **Chlorhexidine Gluconate 0.5% Vaginal Gel**
Qty: #30 gm or: other_____________
Sig: Use 1 gm vaginally as directed
or: _______________________________________________

_______________________________________________ **Refills: 1 2 3 4 5 PRN**

***Healthcare Provider Signature:***
**Print Name**: ________________________________________ **Agent sending**: _______________________________
**NPI**: _______________________________________________ **DEA**: ________________________________________

**Clinic Name:** ____________________________________________
**Clinic Address:** _________________________________________
**Clinic Phone/Fax:** _______________________________________