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

☐ Promethazine Transdermal Cream
(circle strength) **6.25mg/0.1ml** or **25mg/0.2ml**
Qty: (# of doses) _____
Sig: Apply _____ topically to inner wrist every _____ hours as needed.

☐ Ondansetron Transdermal Cream 4mg/0.1ml
Qty: (# of doses) _____
Sig: Apply _____ topically to inner wrist every _____ hours as needed.

_____ **Refills: 1 2 3 4 5 PRN**
Healthcare Provider Signature:
Print Name: _____ **Agent sending**: _____
NPI: _____ **DEA**: _____

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