



Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Call When Ready     Text Message When Ready     Delivery     Mail Out

- Sucrose Octaacetate 10% Topical Bitter Gel (MucoLox™/VersaBase®)**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
- Capsaicin 0.08%/Sucrose Octaacetate 1% Topical Bitter Gel (ZoSil™)**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
- Diphenhydramine HCl 2%/Tranilast 1% Topical Gel (ZoSil™)**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
- Diphenhydramine HCl 2% Topical Gel (ZoSil™)**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
- Diphenhydramine HCl 1%/Dexamethasone Sodium Phosphate 0.05% Topical Gel (ZoSil™)**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
- Diphenhydramine HCl 2% Polyox Bandage**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
- Phenytoin 2%/Misoprostol 0.0024%/Lidocaine 2%/Bupivacaine HCl 0.2%/Diphenhydramine HCl 1%/Aloe Vera 0.2% Polyox Bandage**  
 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: \_\_\_\_\_

