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

☐ **Phenylpropanolamine 12.5 mg/0.1 ml Oral Solution**
Qty: ___________
Sig: ____

☐ **Phenylpropanolamine Capsules**
Strength: __________
Qty: ___________
Sig: ____

☐
Strength:___________
Qty: ___________
Sig: ____

____
Veterinary Healthcare Provider Signature:

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

Print Name: __________________________________ **Agent sending**: __________________________
NPI: ____ **DEA**: __________________________________

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