Date: ____________ Patient Name: ____
DOB: ______________**Address:** ____
City: ______________State: ______ Phone: _____________ Allergies: __________________
□ Call When Ready □ Text Message When Ready □ Delivery □ Mail Out

□ Benzocaine 20%/Lidocaine 6%/Tetracaine 4% Topical Gel
Qty: 30gm, 60gm, 120gm or: _____________
Sig: AAA topically as needed.
Or: ____

□ Benzocaine 20%/Lidocaine 8%/Tetracaine 4% Topical Gel
Qty: 30gm, 60gm, 120gm or: _____________
Sig: AAA topically as needed.
Or: ____

□ Benzocaine 20%/Lidocaine 8%/Tetracaine 8% Topical Gel
Qty: 30gm, 60gm, 120gm or: _____________
Sig: AAA topically as needed.
Or: ____

□ Bupivacaine 1%/Lidocaine 8%/Tetracaine 8% Topical Gel
Qty: 30gm, 60gm, 120gm or: _____________
Sig: AAA topically 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: _____________________________________