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

□ Nystatin 100,000 U/ml Oral Suspension (MucoLox™) Qty: #90 ml or: _____ Sig: Swish and spit 3 ml orally three times daily as needed. Or: _____ **□ Clotrimazole 1% Oral Rinse (MucoLox™)** Qty: #90 ml or: _____ Sig: Swish and spit 3 ml orally three times daily 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: _____