



Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_

Call When Ready     Text Message When Ready     Delivery     Mail Out

**Indomethacin 2%/Tetracaine HCl 2%/Colchicine  
0.2% in Topical Lipoderm® Cream**

Qty: 30gm or: \_\_\_\_\_

Sig: AAA up 2-4 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: \_\_\_\_\_

