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

□ **Vancomycin HCl 2.5% Topical Spray**
Qty: 60 ml
Sig: AAA 2-4 times daily as directed.
Or: _____

□ **Vancomycin 5%/Mupirocin 5% Spira-Wash™ Gel**
Qty: 60 gm
Sig: AAA 2-4 times daily as directed.
Or: _____

□ **Clindaymcin 3%/Doxycycline 1% Topical Ointment**
Qty: 60 gm
Sig: AAA 2-4 times daily as directed.
Or: _____

□ **Mupirocin 2% Topical Gel (PracaSil™ Plus)**
Qty: 60 gm
Sig: AAA 2-4 times daily as directed.
Or: _____

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

Healthcare Provider Signature:
Print Name: _____ **Agent sending**: _____
NPI: _____ **DEA**: _____

Clinic Name: _____
Clinic Address: _____
Clinic Phone/Fax: _____