



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

Hydrocortisone 1%/Lidocaine 2% Rectal Rocket Suppositories

Qty: #5 suppositories or other quantity _____

Sig: Insert one suppository rectally every night at bedtime for 5 nights or _____

Refills: 1 2 3 4 5 PRN

Healthcare Provider Signature:

Print Name: _____ **Agent sending:** _____

NPI: _____ **DEA:** _____

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

