



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

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

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

Call When Ready     Text Message When Ready     Delivery     Mail Out

**Methimazole Topical Lipoderm®**

Strength: \_\_\_\_\_

Qty: \_\_\_\_\_

Sig: \_\_\_\_\_

**Methimazole Oil Oral Suspension**

Strength: \_\_\_\_\_

Qty: \_\_\_\_\_

Sig: \_\_\_\_\_

Qty: \_\_\_\_\_

Sig: \_\_\_\_\_

Refills:    1    2    3    4    5    PRN

\_\_\_\_\_  
*Veterinary Healthcare Provider Signature:*

Print Name: \_\_\_\_\_ Agent sending: \_\_\_\_\_

NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

Clinic Phone/Fax: \_\_\_\_\_

