



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

- Amitriptyline HCl 20 mg/ml Oil Oral Suspension**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
  
- Amitriptyline HCl 5 mg/0.1 ml Topical Lipoderm®**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
  
- Amitriptyline HCl 10 mg/0.1 ml Topical Lipoderm®**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
  
- Buspirone HCl 1.25 mg/0.2 ml Topical Lipoderm®**  
 Qty: \_\_\_\_\_  
 Sig: \_\_\_\_\_
  
- Fluoxetine 5 mg/0.1 ml Topical Lipoderm®**  
 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: \_\_\_\_\_

