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

□ **Terbinafine 1.67%/DMSO Nail Solution**
Qty: 15 ml
Sig: Apply topically to affected nail(s) 1-2 times daily

□ **Terbinafine 1.67%/Tea Tree Oil 10%/Ibuprofen 2%/DMSO Nail Solution**
Qty: 15 ml
Sig: Apply topically to affected nail(s) 1-2 times daily

□ **Itraconazole 1%/Ibuprofen 2%/DMSO Nail Solution**
Qty: 15 ml
Sig: Apply topically to affected nail(s) 1-2 times daily

□ **Ketoconazole 2%/DMSO Nail Solution**
Qty: 15 ml
Sig: Apply topically to affected nail(s) 1-2 times daily

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

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

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