

	Fax		
To:	Park Compounding		From:
Fax:	949-551-1950	Phone: 858-704-4644	Fax:
			Phone:
			Number of Pages: Date:
			Number of Fages Date.
Comm	ents:		
	PROTECTED HEALTH		
	BUSINESS CONFIDEN	ITIAL INFORMATION	
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Ple	ease deliver to:	with this cov	er sheet to protect its contents.



Fax to 949-551-1950

Order Date://	Date Needed By/Date of Administration:/

Please allow for 72-hours turnaround time (3 business days) before order will ship. Incomplete order submissions may delay processing.

Peaceriber Name: DEA. NP##:	Prescriber Information	equired	≣ Patient	Information	Required
Carter/Clinic:	Prescriber Name:		Patient Name:		
Address: City:	DEA: NPI#:		Birthdate:	_// Phone: ()	
Known Drug Allergies:	Center/Clinic:		Address:		
City:	Address:				
Primary Contact:			Known Drug All	lergies:	
Patient Profile(s) or Block Schedule Attached: YES NO (circle one) # of Patients*:	City: State: Zip:				
Email: # of Patients*: Patient requests to pick up prescription at prescriber clinic. If you need a medication not listed, please contact us at 866-551-7195 (toll-free) Medication and Strength Size/Volume Directions Quantit Midazolam / Ketamine HCL/Ondansetron Sublingual Lemon (3/25/2)mg¹ Troche 2-Pack Dissolve 1-2 troches sublingually prior to procedure as instructed by prescriber. *Unused prescription medication should be discarded in conformance with all state and federal laws. The use of a reverse distributor is recommended. Ensure to keep all accurate controlled substance records. Other *Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice *Representative formulation. Customizable within certain ranges. Please contact the pharmacist to discuss. REMINDER: Please check patient information has been included before submitting. Please FAX with cover sheet to ImprimisRx Authorized Prescriber's Signature 949-551-1950 X Please allow for 72-hours turnaround time (3 business days) before order will ship. Incomplete order submissions may delay processing. # of Prescriptions	Phone: () Fax: ()		No Known [Drug Allergies (NKDA)	
Email: # of Patients*: Patient requests to pick up prescription at prescriber clinic. If you need a medication not listed, please contact us at 866-551-7195 (toll-free) Medication and Strength Size/Volume Directions Quantit Midazolam / Ketamine HCL/Ondansetron Sublingual Lemon (3/25/2)mg¹ Troche 2-Pack Dissolve 1-2 troches sublingually prior to procedure as instructed by prescriber. *Unused prescription medication should be discarded in conformance with all state and federal laws. The use of a reverse distributor is recommended. Ensure to keep all accurate controlled substance records. Other *Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice *Representative formulation. Customizable within certain ranges. Please contact the pharmacist to discuss. REMINDER: Please check patient information has been included before submitting. Please FAX with cover sheet to ImprimisRx Authorized Prescriber's Signature 949-551-1950 X Please allow for 72-hours turnaround time (3 business days) before order will ship. Incomplete order submissions may delay processing. # of Prescriptions	Primary Contact:		Patient Profile(s	s) or Block Schedule Attached: VES NO	(circle one)
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·	Credit Card Number: Expira	ation:	_/ 0	CVC Code: Billing Zip:	

Patient Information							
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies			
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	Staff initials						
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