

SOUTHERN DRUGS & DIABETIC SHOPPE

418 EAST MAIN STREET – CHARLESTON, MS 38921

PHONE 662-647-2591 OR TOLL FREE 1-888-571-3533 – FAX 662-647-2411

MEDICATION PRESCRIPTION FORM

PATIENT ID#: _____ DATE: _____, 20____

PATIENT NAME: MR./MS. _____ SS#: _____

ADDRESS: _____ CITY: _____, _____ ZIP: _____

PHONE: _____ BIRTHDAY: _____

PRIMARY: _____ SECONDARY: _____

POLICY #: _____ POLICY #: _____

GROUP #: _____ GROUP #: _____

ADDRESS: _____ ADDRESS: _____

CITY: _____ CITY: _____

ST: _____ ZIP: _____ ST: _____ ZIP: _____

PH#: _____ FX#: _____ PH#: _____ FX#: _____

CHECK APPROPRIATE DIAGNOSIS, PROGNOSIS, AND LENGTH OF NEED

<u>DIAGNOSIS</u>		<u>PROGNOSIS</u>	<u>LENGTH OF NEED</u>
_____ CHRONIC BRONCHITIS (4910)		_____ POOR	_____ LIFETIME
_____ EMPHYSEMA (4920)		_____ FAIR	_____ 12 MONTHS
_____ ASTHMA (49300)		_____ GOOD	_____ 6 MONTHS
_____ COPD (496)		_____ OTHER	_____ OTHER
_____ OTHER _____			

<u>MEDICATION NEEDED</u>			<u>TREATMENTS PER DAY</u>
_____ ALBUTEROL 0.083% (.5/2.5)	_____ ALBUTEROL 0.0415% (.25/1.25)		_____ 2 PER DAY (BID)
_____ INTAL/CHROMLYN 2ml/cc	_____ METAPROTERNOL _____ 0.04% _____ 0.06%		_____ 3 PER DAY (TID)
_____ ACETYLCYSTEINE 10% 4ml	_____ ATROVENT/IPRATROPIUM 0.02% (2.5)		_____ 4 PER DAY (QID)
_____ OTHER _____			_____ 6 PER DAY (Q4H)
_____ 2 DRUG MISTURE (GIVE COMPLETE DESCRIPTION BELOW)			_____ OTHER _____

DOES PATIENT NEED A NEBULIZER? _____ YES _____ NO

PHYSICIAN OR FNP NAME: _____

ADDRESS: _____ CITY: _____, _____ ZIP: _____

PHONE#: _____ FAX#: _____

UPIN#: _____ MEDICAID#: _____ DEA#: _____

(Required)

Physician or FNP Signature: _____

NOTES: _____ (Required)