Patient: _____ Date: ____ / ____ / _____

Species: _____ Date of Birth: ____ / ____ / _____

Client: _____ Phone Number: (_____) _____-_____

Doctor's Name: _____

Phone Number: (_____) _____-_____ DEA or NPI: _____

Anti-Epileptics: Give ____ ml by mouth or rectum ____ times daily.
____ #1 Phenobarbital* ____mg/ml Oral Suspension; _____ ml
____ #2 Potassium Bromide ____ mg/ml Oral Solution; _____ ml
____ #3 Diazepam* ____ mg/ml Rectal Gel; _____ ml

Hyperthyroidism:
____ #1 Methimazole ____ mg/ml Oral Suspension; _____ ml
Directions: Give ____ ml by mouth ____ times daily.
____ #2 Methimazole ____ mg/0.1gm Topical Cream; _____ gm
Directions: Apply ____ gm topically to alternating ear pinas ____ times daily.

Anti-Infectives: Give ____ ml by mouth ____ times daily.
____ #1 Fluconazole ____ mg/ml Oral Suspension; _____ ml
____ #2 Doxycycline ____ mg/ml Oral Suspension; _____ ml

Cardiovascular: Give ____ ml by mouth ____ times daily.
____ #1 Enalapril ____ mg/ml Oral Suspension; _____ ml
____ #2 Amlodipine ____ mg/0.2ml Topical Lipoderm®; _____ ml

Miscellaneous:
____ Anorexia: Cyproheptadine ____ mg/ml Oral Suspension; _____ ml
Give ____ ml by mouth ____ times daily.
____ Topical Antimycotic for Otitis: TRIS 0.6% and EDTA 0.12% Solution; _____ ml
Instill ____ drops into _____ ear(s) ____ times daily.

Flavor: ____ Chicken ____ Liver ____ Fish ____ Beef ____ Bacon (oil) ____Grilled Chicken (oil)

Please indicate if another dosage form (e.g. treats or flavored capsules) is necessary. Numerous other compounded medications are available upon request.

Additional Information: _____

Refills _____ Signature: _____

*Please note that Diazepam and Phenobarbital are **C4** and can have a maximum of 5 refills.

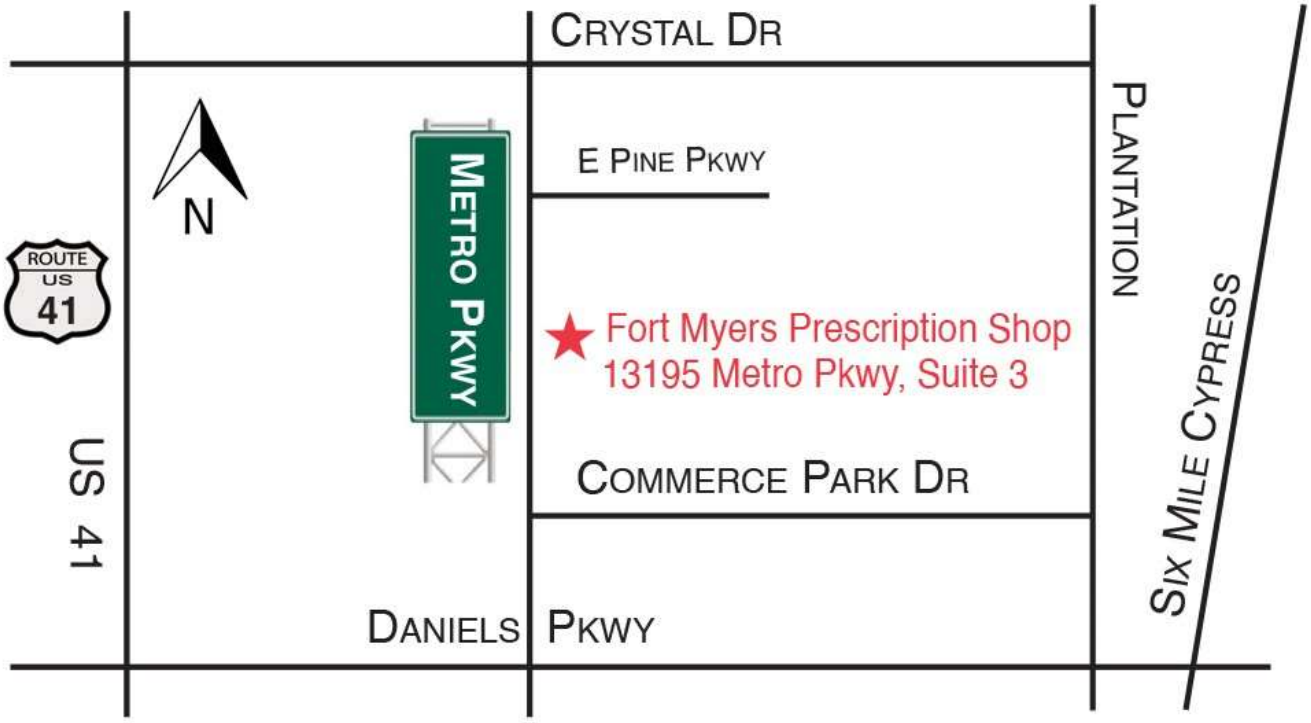
Please bring in or ask your doctor to fax the prescription to

Fort Myers Prescription Shop

13195 Metro Pkwy, suite 3
Fort Myers, FL 33966

Phone: 239-939-0249
Fax: 239-936-2427

Hours: Monday – Friday
8:30 – 1:00 and 2:00 – 5:00



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