PATIENT'S FULL NAME	PHONE NUMBER	AGE	SEX
ADDRESS		DATE / /	

℞

Dr. ______________________
PRODUCT SELECTION PERMITTED

Dr. ______________________
DISPENSE AS WRITTEN

❑ *Refills 1 2 3 4* __________
❑ *No Refills Void After* __________

DEA #: ______________________

VALID FOR CONTROLLED SUBSTANCES

Standard Register