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

Rx

Physician to write, ***"Brand Name Necessary"*** in the box above if brand name is medically necessary.

Dr. _____

DEA #: _____

❑ *Refills* 1 2 3 4 _____

❑ *No Refills* *Void After* _____

VALID FOR CONTROLLED SUBSTANCES