JOHN Q. PUBLIC, MD
A DOCTOR'S OFFICE
100 WEST MAIN STREET
ANY TOWN, ANY STATE 00000
(999) 999-9999

PATIENT'S FULL NAME	PHONE NUMBER	AGE	SEX

ADDRESS	DATE
	/ /

℞

Dr. _____
Signature

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

DEA #: _____

VALID FOR CONTROLLED SUBSTANCES