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

℞

❑ *Refills 1 2 3 4* _____

❑ *No Refills Void After* _____ *Dr.* _____

DEA #: _____

VALID FOR CONTROLLED SUBSTANCES

Any drug which is the generic equivalent of the drug specified above in this prescription may be dispensed, provided no check mark (✓) has been handwritten in the box in the lower right hand corner. ❑