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

Rx

Certified nurse midwife, nurse practitioner, psychiatric nurse, or physician assistant to enter clearly, name of supervising physician

DEA #: _____

❑ *Refills 1 2 3 4* _____

❑ *No Refills Void After* _____

Prescriber's Signature License Classification

Print Name of Prescriber if not Imprinted on Prescription Form

Interchange is mandated unless the practitioner writes the words, ***"No Substitution"*** in this space.