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

℞

| Initials | BRAND MEDICALLY NECESSARY |
|---|---|

*Dr.* _____

❑ *Refills 1 2 3 4* _____

❑ *No Refills Void After* _____

*DEA #* _____

**VALID FOR CONTROLLED SUBSTANCES**