

PATIENT'S FULL NAME

PHONE NUMBER

AGE

SEX

ADDRESS

DATE OF ISSUANCE

/ /

R<sub>x</sub>

Prescriber: \_\_\_\_\_

May Substitute     May Not Substitute

Refills 1   2   3   4   5   \_\_\_\_\_ DEA #: \_\_\_\_\_

No Refills

**VALID FOR CONTROLLED SUBSTANCES**