

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

Rx

Refills 1 2 3 4 \_\_\_\_\_ DEA #. \_\_\_\_\_  
 No Refills Void After \_\_\_\_\_

**VALID FOR CONTROLLED SUBSTANCES**

Dr. \_\_\_\_\_ SUBSTITUTION PERMITTED  
 Dr. \_\_\_\_\_ DISPENSE AS WRITTEN