

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

R<sub>x</sub>

Physician to write, "**Brand Name Necessary**" in the box above if brand name is medically necessary.

- Refills 1 2 3 4 \_\_\_\_\_
- No Refills Void After \_\_\_\_\_

Dr. \_\_\_\_\_

DEA #: \_\_\_\_\_

**VALID FOR CONTROLLED SUBSTANCES**