Up to 6 Lines of print

DOCTOR'S NAME(S)

Medical Center or Clinic

Your Building • Your Address

City, State, Zip • Phone

Doctor(s) Practice

Dr. Name and Title

Your Form Number and Revision Date

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Name ______________________ Date ______________

Address ______________________ Age ______________

LABEL NAME OF DRUG - STRENGTH AND QUANTITY		☐ YES			☐ NO				PHARMACY
℞ 1									℞ 1
SIG.									
DSPSE.	mg./cc.	REFILL	0	1	2	3	4	5	
℞ 2									℞ 2
SIG.									
DSPSE.	mg./cc.	REFILL	0	1	2	3	4	5	
℞ 3									℞ 3
SIG.									
DSPSE.	mg./cc.	REFILL	0	1	2	3	4	5	

Three Rx Format

______________________ M.D.
Dispense As Written

______________________ M.D.
Substitution Permitted

PRN NR DEA No. ______________________