

Prescriber Name (Print) _____
State License # _____ DEA # _____
Office Address _____
City/State/Zip _____
Phone # _____ Fax # _____ For Internal Use **RSF-TS**

RX ORDER FORM - Cash or Credit Card Patient

1 Patient's Name _____ Phone # _____
D.O.B. _____ Allergies _____
Patient Shipping Address _____
We only ship to U.S. physical mailing addresses no P.O. Boxes.
Patient Billing Address (check if same) _____
Patient Email *required (Please send the receipt to the following e-mail address) _____
CC#: (circle) MC VS AMEX DC _____ Exp. _____ Security Code _____
Diagnosis _____

2 RX – Transdermal Compounds

- Muscle Magick™**
(cyclobenzaprine HCL 2% / ketoprofen 10% / tetracaine HCL 3% / menthol 10% / camphor 2%) LDS
Quantity: ___30 or ___60 gram jar Sig: Apply a thin layer to affected area twice daily as directed by physician.
- Gym Gel™**
(indomethacin 10% / lidocaine 5% / tetracaine HCL 3% / glucosamine 5% / capsaicin 0.0375%) LDS
Quantity: ___30 or ___60 gram jar
 Sig: Apply a thin layer to affected area twice daily, dosed 6 hours apart, then withhold for 12 hours.
 Sig: _____

3 (Must Complete This Section) **TOTAL # OF RXs PRESCRIBED** _____ **AUTO REFILLS** _____
UPON PATIENT REQUEST, PLEASE FAX DIRECTLY FROM THE M.D.'S OFFICE TO (949) 266-8210.

I CERTIFY THAT THIS DRUG ORDER IS BEING ISSUED FOLLOWING A GOOD FAITH PRIOR EXAMINATION OF THE PATIENT AT WHICH BOTH THE PATIENT AND I WERE PRESENT.

Prescriber Signature _____ Date _____