



AAF Member : Compounded Prescription Order Form

Patient's First Name	
Patient's Last Name	
Patient's Weight	
Medication ordered (MB12 / DMSA / EDTA / DMPS or other)	
Address	
Phone #	
Date of Birth (mm/dd/yyyy)	
Allergies to Medication	
Parent's Names for KYC Document	

PS: Make Sure you also attach the latest prescription from the doctor.

I agree Akhil Autism Foundation doesn't recommend any of the compounded prescription and its only for educational purpose. And we are doing this under local doctor's guidance and prescription. For any side effects I /we do not hold Akhil Autism Foundation responsible. I understand these compounding prescriptions are not approved by FDA and its our responsibility to educate and do under doctor's supervision.

Parent's Name: _____ **Sign :** _____

Email: _____ **Date(mm/dd/yyyy) :** _____

Please Note: All orders will be processed on Mon-Fri business days, no processing on weekends. Follow ups via email only. WhatsApp follow ups for only Urgent orders. AAF does not ship these, we are just the facilitators and help you connect with service providers. Feel free to directly contact Hopewell Pharmacy during business hours after approval.