

Hopewell Pharmacy & Compounding Center

Fax: 800-417-3864 or 609-466-8222

Fax Medication Order Form

Amphotericin B

Capsule Suspension

Sig & Strength: _____

Quantity: _____

BH4 Oral Capsule

10mg 20mg

Quantity: _____

Cholestyramine Powder

2g in the AM on an empty stomach

4g in the AM on an empty stomach

Quantity: _____

DMSA

Capsule Suppository

Sig & Strength: _____

3mL pre-filled syringes (Transdermal)

Sig and Strength: _____

Quantity _____

DMPS

Capsule Quantity: _____

Sig & Strength: _____

3mL pre-filled syringes (TD)

Sig: Apply _____mg QOD

syringes _____ (1-1 1/2 mg/kg)

Suppository Sig & Strength:

Glutathione Transdermal

100mg/g 200mg/g

250mg/g

30g 60g 3mL PF syringes

Sig: Apply _____g QD BID

Inhalation

Sig & Strength: _____

Quantity: _____

Nasal Spray 30mL

10% 20% 30%

Sig: _____ sprays _____

Methylfolate Capsule

7.5mg 15mg

Sig: _____

Quantity: _____

Methylcobalamin Injectable

12.5mg/mL 25mg/mL

Volume of syringe _____

of pre-filled syringes _____

vial _____ mL

BD 31g syringes (bags of 10) _____

Sig: Inject _____cc

QD BIW

Q3D Other _____

Nasal Spray (7mL)

12.5mg/mL 25mg/mL

with folic acid _____mg/mL

1 spray 2 sprays

QD Other _____

Naltrexone Transdermal

Quantity of 3mL syringes: _____

Sig and Strength: _____

Oxytocin Nasal Spray

10 U/ml 40 U/ml 80 U/ml

QD BID Other _____

SL Troche

5U 10U

Sig: _____

Other:

Refills: 0 1 2 3 4 5 6 PRN

Patient Name: _____

Patient Phone: _____

Doctor Name: _____ **DEA #:** _____

Signature: _____ **Date:** _____