

COMPOUNDED TOPICAL SINUS MEDICATION ORDER FORM

PATIENT NAME: _____	DOB: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
PRIMARY PHONE#: _____	SECONDARY PHONE#: _____	
ADDRESS: _____		
CITY: _____	STATE: _____	ZIP: _____
ALLERGIES: _____		

DELIVERY METHOD

<input type="checkbox"/> NeilMed® sinus rinse bottle. Add contents of 1 capsule and saline pack to 240mL of distilled water. Irrigate each nostril with half bottle of medication twice daily	<input type="checkbox"/> NasoNeb® nasal nebulizer. Add contents of capsule to 15mL of saline. Nebulize into both nostrils twice daily
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CHECKING BOX INDICATES BID X 30 DAYS UNLESS ALTERNATIVE DIRECTIONS ARE MARKED

DRUG	REFILLS	SIG	DAYS	DRUG	REFILLS	SIG	DAYS
<input type="checkbox"/> Azithromycin 50mg				<input type="checkbox"/> Levofloxacin 100mg			
<input type="checkbox"/> Betamethasone 0.5mg				<input type="checkbox"/> Mometasone 0.6mg			
<input type="checkbox"/> Budesonide 0.6mg				<input type="checkbox"/> Mometasone 1mg			
<input type="checkbox"/> Ciprofloxacin 125mg				<input type="checkbox"/> Mupirocin 15mg			
<input type="checkbox"/> Clindamycin 50mg				<input type="checkbox"/> Mupirocin 30mg			
<input type="checkbox"/> Diphenhydramine 15mg				<input type="checkbox"/> Nystatin 50,000 IU			
<input type="checkbox"/> Doxycycline 30mg				<input type="checkbox"/> SMZ-TMP160mg/32mg			
<input type="checkbox"/> Gentamicin 20mg				<input type="checkbox"/> Tobramycin 20mg			
<input type="checkbox"/> Itraconazole 40mg				<input type="checkbox"/> Vancomycin 160mg			

OTHER: _____

PRESCRIBER INFORMATION

Name: _____	NPI: _____	Lic# _____
Address: _____	City: _____	State: _____ Zip: _____
Phone: _____	Fax: _____	
Prescriber Signature: _____		Date: _____

FAX FORM TO PHARMACY OF CHOICE

Pharmacy Name: ADVANCED RX 060 Fax#: 1-615-866-6293