ALLIED PHARMACY

Workers Comp

Ph: 832-365-3420 Fax: 855-595-2955

☐ New Patient

Date

Patient Name_____DOB_____Weight_____ ☐ Male ☐ Female

Street Address:_____Apt #_____City_____State_____Zip_____

Phone #_____Cell #_____Allergies_____

ICD 9 Code: _____

☐ **Zofran** ☐ 4 mg ☐ 8 mg
☐ **Phenergan** ☐ 25 mg ☐ 50 mg
Sig:_____ Qty:_____ Refills_____

☐ **Amitriptyline** ☐ 10mg ☐ 25mg ☐ 50mg ☐ 75mg ☐ 100mg
☐ **Venlafexine ER** ☐ 37.5mg ☐ 75mg ☐ 150mg
Sig:_____ Qty:_____ Refills_____

☐ **Cyclobenzaprine** ☐ 5mg ☐ 10mg
☐ **Tizanidine** ☐ 2mg ☐ 4mg ☐ 6mg
☐ **Methocarbamol** ☐ 500mg ☐ 750mg
Sig:_____ Qty:_____ Refills_____

☐ **Celebrex** ☐ 100mg ☐ 200mg ☐ 400mg
Sig:_____ Qty:_____ Refills_____

☐ **Ibuprofen** ☐ 600mg ☐ 800mg
☐ **Naproxen** ☐ 375mg ☐ 500mg
☐ **Etodolac** ☐ 300mg ☐ 400mg ☐ 500mg
☐ **Meloxicam** ☐ 7.5mg ☐ 15mg
Sig:_____ Qty:_____ Refills_____

☐ **Cymbalta** ☐ 20mg ☐ 30mg ☐ 60mg
☐ **Gabapentin** ☐ 100mg ☐ 300mg ☐ 400mg,
☐ 600mg ☐ 800mg
Sig:_____ Qty:_____ Refills_____

☐ **Methylprednisone Dosepack** ☐ 4mg
☐ **Prednisone** ☐ 5mg ☐ 10mg ☐ 20mg
Sig:_____ Qty:_____ Refills_____

☐ **Famotidine** ☐ 20mg ☐ 40mg
Sig:_____ Qty:_____ Refills_____

ALL controlled substance quantities must be hand written in number and letter form

ADDITIONAL INJURED WORKER MEDICATION

OSTEOARTHRITIS:
**Dosing = Take 1 capsule 3 times daily*
☐ **Synovacin**
☐ **Genicin**
QTY: ☐ 90 (Ninty) ☐ 180 (One-Hundred Eighty)
Refills: ☐ 1 (One) ☐ 2 (Two) ☐ 3 (Three)

STOOL SOFTNER:
**Dosing = Take with full glass of water (8oz).*
Do not take medicine more than directed.
☐ **Laxacin**
☐ **Docusate 100mg** Up to QID
QTY: ☐ 100 Refills: ☐ 1 (One) ☐ 2 (Two) ☐ 3 (Three)

SLEEP DISORDER:
☐ **Somnicin**
**Dosing = Take 1 tablet 30 minutes prior to bedtime*
☐ **SentraPM**
**Dosing = Take 1 or 2 capsules 30 minutes prior to bedtime*
QTY: ☐ 30 (Thirty) ☐ 60 (Sixty) ☐ 90 (Ninty)
Refills: ☐ 1 (One) ☐ 2 (Two) ☐ 3 (Three)

☐ **Capsaicin 0.038% + Menthol 5%** (For Pain)
☐ **Lidocaine HCL 4% + Menthol 1%** (For Pain)
**Dosing = Apply 1 - 3 patches to affected area daily*
QTY: ☐ 30 (Thirty) ☐ 60 (Sixty) ☐ 90 (Ninty)
Refills: ☐ 1 (One) ☐ 2 (Two) ☐ 3 (Three)

PAIN AND INFLAMATION:
☐ **Theramine** ☐ 120
For dietary management of pain syndromes that include **chronic pain, fibromyalgia, neuropathic pain**, and **inflammatory pain**
Take two (2) capsules twice daily or as needed under physicain supervision

☐ **Trepadone** ☐ 120
For the dietary management of pain associated with **osteoarthritis**
Take two (2) capsules twice daily
Refills: _____ ☐ 1 (One) ☐ 2 (Two) ☐ 3 (Three)

☐ **GABAdone** ☐ 60
For the dietary management of sleep disorders associated with anxiety
Take one (1) or two (2) capsules at bedtime to initiate sleep
QTY:_____ Refills: _____ ☐ 1 (One) ☐ 2 (Two) ☐ 3 (Three)

Prescriber's Name _____ Office Contact_____

Street Address _____Suite #_____ City _____ State _____ Zip _____

Telephone_____ License # _____ NPI # _____ DPS # _____ DEA #_____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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FDA BLACK BOX WARNING: [NSAID] may cause an increased risk of serious cardiovascular thrombotic event, myocardialinfarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular diesase or risk factors for cardiovascular diease may be at greater risk.

Please fax completed form to 1 855-595-2955