

DATE \_\_\_\_\_



COMPOUNDING  
INFUSION  
MEDICAL SUPPLIES  
SPECIALTY MEDICATIONS

## WOMEN'S HEALTH

655 Dearborn Park Lane, Worthington, OH, 43085  
Phone: (614) 847-6007 | Fax: (614) 847-6015 | totani@sbhmed.com

Rx Order Form

### PATIENT

TXT Preferred\* \_\_\_\_\_

NAME \* \_\_\_\_\_ DOB \* \_\_\_\_\_ PHONE \* \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

ALLERGIES \* \_\_\_\_\_ EMAIL \* \_\_\_\_\_

### PRESCRIPTION

#### PRENATAL AND POSTPARTUM

##### PREGNANCY NAUSEA AND VOMITING

DOXYLAMINE SUCCINATE 10mg/  
PYRIDOXINE HCl SUPPOSITORY 10mg

Quantity: 30 60 90 Refills: 1 2 3 4 5 prn

##### PROGESTERONE VAGINAL SUPPOSITORY

50mg  100mg  200mg  \_\_\_\_\_ mg

Daily at bedtime

Days morning and at bedtime

Quantity: 30 60 90 Refills: 1 2 3 4 5 prn

NIPPLE CREAM (JACK NEWMAN'S)  
MUPIROCIN 1% / BETMETHASONE 0.05% /  
MICONAZOLE 2% OINTMENT

Quantity: 1 30gm jar Refills: 1 2 3 4 5 prn

#### HEMORROID RELIEF

RECTAL ROCKETTS  
LIDOCAINE 2% / HYDROCORTISONE 1%

Quantity: \_\_\_\_\_ Refills: 1 2 3 4 5 prn

#### SEXUAL WELLNESS

##### VAGINAL REVITALIZING OIL

ALMOND OIL BASE, PALMAROSA OIL

60ml

Quantity: 1tube 2tubes Refills: 1 2 3 4 5 prn

##### O CREAM OR SCREAM CREAM

AMINOPHYLLINE / ISOSORBID DINITRATE / L-ARGININE

Sig: Apply dose topically

QD  BID

Quantity: \_\_\_\_\_ Refills: 1 2 3 4 5 prn

##### ATROPHIC VAGINITIS

DHEA VAGINAL CREAM OR DHEA VAGINAL SUPPOSITORY

30mg  60mg  90mg

Quantity: 30 60 90 Refills: 1 2 3 4 5 prn

#### PELVIC PAIN AND INFECTION

DIAZEPAM 5mg SUPPOSITORY

Quantity: 30 60 Refills: 1 2 3 4 5 prn

GABAPENTIN 6% VAGINAL CREAM

AMITRIPTLINE HCl 2% / BACLOFEN 2% VAGINAL CREAM

15gm  30gm  45gm

Quantity: 1tube 2tubes Refills: 1 2 3 4 5 prn

BORIC ACID 600mg VAGINAL SUPPOSITORY OR CAPSULE

Quantity: 10 Day Supply Refills: 1 2 3 4 5 prn

LICHEN SCLEROSIS

CLOBETASOL PROPIONATE 0.05% TOPICAL OINTMENT

15gm  30gm  45gm

Quantity: 1tube 2tubes Refills: 1 2 3 4 5 prn

### CUSTOM ORDER

RX \_\_\_\_\_ QUANTITY \_\_\_\_\_ gm

SIGNATURE \_\_\_\_\_ REFILL(S) \_\_\_\_\_

### PRESCRIBER

NAME \_\_\_\_\_ SIGNATURE \* \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_ ORDER SENT BY \_\_\_\_\_

DEA # \_\_\_\_\_ STATE LICENSE # \_\_\_\_\_ NPI # \_\_\_\_\_

\* Required fields

FAX COMPLETED FORM TO (614) 847-6015