



678 WYCKOFF AVE  
 WYCKOFF NJ 07481  
 P 201 891 3334  
 F 201 891 1312

**RECTAL CREAMS ORDER FORM**

PATIENT INFORMATION		
FIRST NAME:	LAST NAME:	
PRIMARY PHONE #: <input type="radio"/> CELL <input type="radio"/> HOME <input type="radio"/> WORK	SECONDARY PHONE #: <input type="radio"/> CELL <input type="radio"/> HOME <input type="radio"/> WORK	
ADDRESS:	CITY, STATE, ZIP:	ALLERGIES:

MEDICATIONS				
<input type="checkbox"/> Diltiazem	<input type="radio"/> 2% or	<input type="radio"/> ____%	Cream	<input type="radio"/> 30gm <input type="radio"/> 60gm
<input type="checkbox"/> Diltiazem / Lidocaine	<input type="radio"/> 2% / 1% or	<input type="radio"/> ____% / ____%	Cream	<input type="radio"/> 30gm <input type="radio"/> 60gm
<input type="checkbox"/> Nifedipine	<input type="radio"/> 0.2% or	<input type="radio"/> ____%	Ointment	<input type="radio"/> 30gm <input type="radio"/> 60gm
<input type="checkbox"/> Nifedipine / Lidocaine	<input type="radio"/> 0.2% / 1% or	<input type="radio"/> ____% / ____%	Ointment	<input type="radio"/> 30gm <input type="radio"/> 60gm
<input type="checkbox"/> Nitroglycerin	<input type="radio"/> 0.3% or	<input type="radio"/> ____%	Ointment	<input type="radio"/> 30gm <input type="radio"/> 60gm
<input type="checkbox"/> Nitroglycerin / Lidocaine	<input type="radio"/> 0.3% / 1% or	<input type="radio"/> ____% / ____%	Ointment	<input type="radio"/> 30gm <input type="radio"/> 60gm

**SIG (Applies to all options)**

**Apply a pea sized amount \_\_\_\_ times daily rectally as directed.**

Refills:  1  2  3  4  5  6  PRN  NR SIG: \_\_\_\_\_

WRITE PRESCRIPTION / ADDITIONAL COMMENTS			

DOCTOR	PHONE	NPI #	DEA #
OFFICE MANAGER	PHONE	OFFICE FAX	OFFICE Email
SIGNATURE		DATE (Month / Day / Year)	<b>FAX TO 201-891-1312</b> email to: <a href="mailto:orders@yourlifex.com">orders@yourlifex.com</a>
		_____/_____/_____	