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

SPORTS MEDICINE ORDER FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME:

PRIMARY PHONE #: ◯ CELL ◯ HOME ◯ WORK SECONDARY PHONE #: ◯ CELL ◯ HOME ◯ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

SPORTS MEDICINE

	Medication	Form	Size
☐	Aluminum Chlorohydrate 5%	Topical Powder	○ 1oz / ○ 2oz / ○ 4oz / _____ oz
☐	Diclofenac Sodium 10%	Topical Cream	○ 1oz / ○ 2oz / ○ 4oz / _____ oz
☐	Flurbiprofen 10% / Baclofen 2% / Cyclobenzaprine 2% / Tetracaine 2%	Topical Cream	○ 1oz / ○ 2oz / ○ 4oz / _____ oz
☐	Flurbiprofen 10% / Cyclobenzaprine 1% / Gabapentin 6% / Lidocaine 2% / Prilocaine 2%	Topical Cream	○ 1oz / ○ 2oz / ○ 4oz / _____ oz
☐	Glutathione 20%	Topical Cream	○ 1oz / ○ 2oz / ○ 4oz / _____ oz
☐	Itraconazole 1% / Ibuprofen 2% / DMSO	Nail Solution	○ 1oz / ○ 2oz / ○ 4oz / _____ oz
☐	Ketoprofen 10% / Tizanidine 0.2% / Bupivacaine 1%	Topical Cream	○ 1oz / ○ 2oz / ○ 4oz / _____ oz
☐	Magnesium Sulfate Heptahydrate 10%	Topical Cream	○ 1oz / ○ 2oz / ○ 4oz / _____ oz
☐	Tea Tree Oil 5.4% / Lavender Oil 1% / Clotrimazole 1% / Undecylenic Acid 5% / Urea 5%	Topical Cream	○ 1oz / ○ 2oz / ○ 4oz / _____ oz

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) ______/_____/______	

FAX TO 201-891-1312

email to: orders@yourliferx.com