BOTOX PRESCRIPTION FORM

Patient Information

Name:

Last	First	Initial
Sample	Patient	B

Street	City/Town	Province	Postal Code
123 Main St. Apt. 218	Dartmouth	NS	B2B 2B2

Telephone:

Home (902) 555-0248 Work (902) 555-1729 Cell: _____

Date Of Birth: (DD/MM/YR) 14 / 3 / 1969 *Gender* : M (F)

Medicare #: 0000 000 000 *Insurance company name:* Pellentesque

Primary Plan Holder's name: Patient Sample *Relationship to patient*: n/a

Carrier ID# 023698 *Health Plan/Group ID # :* 0126942 *Patient ID#:* 12436

Drug Allergies: iaculis, pharetra, tellus

Pharmacy Information

Address: Test Pharmacy
456 Any St.
Halifax, NS B1B 1B1

Pharmacist: Jane Tester

Telephone: (902) 555-3106 Fax: (902) 555-0143

Prescription Information

BOTOX THERAPEUTIC (Botulinum Toxin type A) DIN 01981501
For Injection

Quantity: _____ (100Units per vial) Quantity: 3 (50Units per vial)

Repeats: 2

Prescriber Certification

- This prescription represents the original of the prescription drug order.
- The pharmacy address noted above is the only intended recipient and there are no others.
- The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.

MD's Signature: _____ Date: 08/04/2014

Doctor: DR. REQUESTING PHYSICIAN Phone: (902) 555-5555 Fax: (902) 555-5732

Indication: sed ultrices risus

Prior treatment: Vehicula quis. Aliquam suscipit placerat metus.

Shipping Information

Deliver the medication at the MD's office/clinic at: [X] PHYSICIAN'S NAME: DR. REQUESTING PHYSICIAN
NAME OF THE CLINIC: Test Clinic 18
ADDRESS: 123 Any St., Suite 147
Halifax, NS B1B 1B1

[X] NEXT APPOINTMENT DATE 26/04/2014 [ ] STAT APPOINTMENT / /