



# Compounded Drug Prescription Order Form

Complete the following

Date: \_\_\_\_\_

## Prescriber Information

Veterinarian's Name: \_\_\_\_\_ Veterinarian's License #: \_\_\_\_\_  
 Clinic Name: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ DEA#: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Veterinarian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Pet and Pet Owner Information

Pet's Name: \_\_\_\_\_ Species: \_\_\_\_\_  
 Breed: \_\_\_\_\_ Sex:  Male  Female Spayed/Neutered:  Yes  No  
 Date of Birth: \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Recorded Date: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Pet Owner Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Phone: \_\_\_\_\_

## Prescription

| Medication | Strength | Directions | Quantity | Refills |
|------------|----------|------------|----------|---------|
|            |          |            |          |         |
|            |          |            |          |         |
|            |          |            |          |         |

Date order is needed by: \_\_\_\_\_ Ship to:  Pet Owner's Address  Other

Other address: \_\_\_\_\_

Fax your prescription to 866-685-7608 or 850-944-7979 or email to: [pharmacist@ProPharmRx.com](mailto:pharmacist@ProPharmRx.com)  
 We will contact you separately to verify order and other information as required to process the order.