**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alt Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ Gender: □ Male □ Female

***Our Family of Pharmacies:***

* **Chris’ Pharmacy and gift’s**

**(Maurepas, LA)**

* **Chris’ Pharmacy and Gifts**

**(Port Vincent, LA)**

* **John’s Pharmacy in Albany**

**(Albany, LA)**

* **Redstick Pharmacy**

**(Baton Rouge LA)**

**PRESCRIPTION INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication & Strength** | **Directions** | **Qty** | **Refills** |
| **Sildenafil 20 mg**  **90 tablets for $69** | Take 2-5 tablets as directed | #50 |  |
| **Sildenafil RDT:**  (Rapid Dissolve Tablet)  50mg  100mg  **$10/tablet or $180/30 Tablets any strength.** | Dissolve one tablet in mouth 30 minutes before needed  (max 1 tablet per 24 hours) |  |  |
| **Tadalafil RDT:**  (Rapid Dissolve Tablet)  10mg  20mg  **$10/tablet or $180/30 Tablets** | Dissolve one tablet in mouth30 minutes before needed  (max 1 tablet per 72hours) |  |  |
| **Tadalafil RDT:**  (Rapid Dissolve Tablet)  2.5mg  5mg  **$4/Tablet or $70/30 Tablets** | Dissolve one tablet in mouth daily |  |  |
| **Vardenafil RDT**  (Rapid Dissolve Tablet)  2.5mg  5mg  10mg  20mg  **$10/tablet or $180/30 Tablets** | Dissolve one tablet in mouth 60 minutes before needed.  (max 1 tablet per 24 hours) |  |  |

**PRESCRIBER INFORMATION:**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_LA\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DEA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Physician’s Signature

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