GATEWAY MEDICAL PHARMACY

Phone: (503) 254-7383 • Fax: (503) 254-4568

TOPICAL PAIN COMPOUND ORDER FORM

Patient Information:

Name:_____ DOB:_____ Phone:_____

Address:_____ Allergies:_____

Please select which ingredients, and specify the strength, you would like to prescribe:

◯ Amitriptyline Strength _____%

◯ Cyclobenzaprine Strength _____%

◯ Diclofenac Strength _____%

◯ DMSO Strength _____%

◯ Gabapentin Strength _____%

◯ Ketamine Strength _____% (**Provide DEA # below**)

◯ Ketoprofen Strength _____%

◯ Lidocaine Strength _____%

◯ Menthol Strength _____%

◯ Orphenadrine Strength _____%

◯ Tetracaine Strength _____%

Base: ◯ Gel (~30-day exp) ◯ Cream (~30-day exp) ◯ Ointment (~**60**-day exp)

Directions for use (please include a route, quantity, and frequency EX: Apply 1mL topically daily):

_____

_____

Prescriber Printed Name:_____ Phone:_____

Prescriber Signature:_____ Date_____

Prescriber DEA #: _____ NPI#: _____

Clinic Name and Address:_____