

LETTER OF PROTECTION/LIENS SCRIPT PAD

Ph: (214) 919-2090 or (877) 753-6878

Fax: 1 (888) 294-9434

Patient Name: _____ DOB: _____ Weight: _____ Male Female
Street Address: _____
Apt #: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____
Attorney: _____ DOI: _____
Phone: _____ Fax: _____

Bill to: Attorney PIP (Personal Injury Protection)

PRESCRIPTION

<input type="checkbox"/> Cyclobenzaprine <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg	SIG: 1 2 3	TAB	PO	QD	BID	TID	QTY: _____ Refills _____	
<input type="checkbox"/> Amitriptyline <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	SIG: 1 2 3	TAB	PO	QD	BID	TID	QTY: _____ Refills _____	
<input type="checkbox"/> Ibuprofen <input type="checkbox"/> 800mg <input type="checkbox"/> 600mg	SIG: 1 2 3	TAB	PO	QD	BID	TID	QTY: _____ Refills _____	
<input type="checkbox"/> Naproxen <input type="checkbox"/> 375mg <input type="checkbox"/> 500mg	SIG: 1 2 3	TAB	PO	QD	BID	TID	QTY: _____ Refills _____	
<input type="checkbox"/> Gabapentin <input type="checkbox"/> 300mg <input type="checkbox"/> 400mg <input type="checkbox"/> 600mg	SIG: 1 2 3	TAB	PO	QD	BID	TID	QTY: _____ Refills _____	
<input type="checkbox"/> Tizanidine <input type="checkbox"/> 2mg <input type="checkbox"/> 4mg	SIG: 1 2 3	TAB	PO	QD	BID	TID	QTY: _____ Refills _____	
<input type="checkbox"/> Methocarbamol <input type="checkbox"/> 500mg <input type="checkbox"/> 750mg	SIG: 1 2 3	TAB	PO	QD	BID	TID	QTY: _____ Refills _____	
<input type="checkbox"/> Diclofenac Sodium <input type="checkbox"/> 75mg <input type="checkbox"/> 50mg	SIG: 1 2 3	TAB	PO	QD	BID	TID	QTY: _____ Refills _____	
<input type="checkbox"/> Omeprazole <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	SIG: 1 2 3	TAB	PO	QD	BID		QTY: _____ Refills _____	
<input type="checkbox"/> Ranitidine <input type="checkbox"/> 150mg <input type="checkbox"/> 300mg	SIG: 1 2 3	TAB	PO	QD	BID		QTY: _____ Refills _____	
<input type="checkbox"/> Meloxicam <input type="checkbox"/> 7.5mg <input type="checkbox"/> 15mg	SIG: 1 2 3	TAB	PO	QD	BID		QTY: _____ Refills _____	
<input type="checkbox"/> Citalopram <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	SIG: 1 2 3	TAB	PO	QD			QTY: _____ Refills _____	
<input type="checkbox"/> Medrol Dose Pack	SIG: _____	Use As Directed on package						
<input type="checkbox"/> Prednisone 10mg	SIG: _____						QTY: _____ Refills _____	
<input type="checkbox"/> Capsaicin 0.025% 60gm	SIG: _____						QTY: _____ Refills _____	
<input type="checkbox"/> Salonpas Patch	SIG: _____						QTY: _____ Refills _____	

Rx

ALL controlled substance quantities must be hand written in number and letter form

Prescriber's Name: _____ Office Contact: _____
Street Address: _____ Suite #: _____
City: _____ State: _____ Zip: _____ Tel: _____
License #: _____ NPI #: _____ DPS #: _____ DEA #: _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date: _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Medicare and Medicaid or another state funded program will not cover above mentioned compounds. Co-payments due at dispensing of the medication

Please fax completed form to 1 (888) 294-9434