PRESCRIPTION FORM

Prescribing Physician: _____

Physician License Number: _____

Office Address: _____

Office Phone: _____

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

Phone / Email: _____

Medication Details:

Medication Name: _____

Dosage (e.g., 10 mg): _____

Form (e.g., tablet, capsule, liquid): _____

Quantity: _____

Directions for Use: _____

(e.g., Take one tablet by mouth twice daily)

Refills Authorized: _____

Warnings and Special Instructions:

Patient must notify the prescribing physician if experiencing any adverse reactions or allergies related to the medication. Medication should be stored securely and out of reach of children. Follow all federal and state laws regarding controlled substances. Do not share this medication with others.

Physician Certification and Signature:

I hereby certify that I am the prescribing physician authorized to issue this prescription and that this prescription is written in good faith in accordance with applicable federal and state laws and regulations. I have evaluated the patient and determined that this medication is medically necessary. I acknowledge my responsibility to maintain a valid physician-patient relationship and to comply with all reporting requirements.

Physician Signature: _____

DEA Number (if applicable): _____

Pharmacy Use Only:

Pharmacist Name:

This prescription complies with all applicable United States federal and state laws and regulations governing prescription medications. Unauthorized use, duplication, or distribution is prohibited. Any alteration, forgery, or unauthorized copying of this form is unlawful and subject to penalties under applicable law.

PHYSICIAN SIGNATURE

Date: _____

PHARMACIST SIGNATURE

Date: _____