Prescription Form

Form Info & Sign-off

Today's Date ____ / ____ / _____ Date Medication Needed in Hand ____ / ____ / _____ Time _____ ☐ AM ☐ PM

Physicians Signature X _____

Prescriber Information

First Name _____ Last Name _____

DEA# _____ License# _____ NPI # _____

Practice /Clinic Name _____ Address _____

City _____ State* _____ Zip _____ Phone _____

Fax _____ Office Contact _____ Phone _____

Supervising Physician _____ Phone _____ DEA # _____

Address _____ City _____ State _____ Zip _____

* If prescriber state different than destination/shipping state:

Date last seen in office ____ / ____ / _____ OR Destination state prescriber license # _____ DEA # _____

Patient Information

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____ Birthdate ____ / ____ / _____

Preferred Phone _____ Alternative Phone _____

Allergies _____ DL#/State (for controls only) _____ / _____

Compounding Information

*Controlled substances must be on a separate Rx and DEA# entered above

Qty.	Compound	Form	Strength	Size	Sig (Directions)	Refills

Billing, Shipping & Special Instructions

☐ Charge to Doctor OR ☐ Charge to Patient

☐ Ship to doctor OR ☐ Ship to Patient

Shipping Type: ☐ Overnight ☐ 2nd Day ☐ 3rd Day ☐ Ground

Special Instructions A4M Spotlight

Payment Information

Cardholder Name _____ Phone _____

Cardholder Signature _____

Card Number _____ Exp. Date _____ CVV Code _____

Credit Card Billing Address _____

City _____ State _____ Zip _____