YOUR HEALTH PHARMACY

12 N Federal Hwy, Suite A
Pompano Beach FL, 33062
NPI 1649771171 / NCPDP 5736939
Phone (866) 478-3761
Fax (888) 510-2297
Email: rx@yhpharmacy.com

NASAL SYMPTOM & PAIN MANAGEMENT

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Allergies: □ NKDA (no known drug allergies) □ Aspirin/ NSAID's □ Cyclobenzaprine □ Lidocaine / Local Anesthetic □ Tramadol □ Opioid
□ Gabapentin □ Penicillin □ Amitriptyline □ Other: _____

NASAL SYMPTOM MANAGEMENT

1. ____ Budesonide 1.0mg-2ml Vial #360 (720ml) – empty 2 vials into IDS, add distilled water, irrigate 1 – 2 times daily
   a. If checked, pharmacy is authorized to dispense the below in lieu of the medication listed in #1 above if needed for any reason or if desired by patient
      i. ____ Budesonide 1.0mg-2ml Vial #180 (360ml) – empty 1 vial into IDS, add distilled water, irrigate 1 – 2 times daily
      ii. ____ CMPD Budesonide 0.5mg in Loxasperse Cap #180 – empty 1 cap into IDS, add distilled water, irrigate 1 – 2 times daily

If CHECKED, also dispense the following with the above
Dispense #180 for 90-day supply – Empty 1 cap into IDS, add distilled water, irrigate 1-2 times daily

____CMPD Azelastine HCL 500mcg Cap _____ CMPD Theophylline 100mg Cap _____

____CMPD Acetylcystiene 100mg Cap _____ Other _____

Additional Delivery Device (Dispense #1 Along with IDS – Use as directed)

____Small Particle Size Nasal Atomizer RhinoClear® Sprint _____ Neti-Flow® Nasal Irrigation System

PAIN MANAGEMENT

1. ____ CMPD Topical Cream – Diclofenac Sodium 1.5%, Lidocaine 2.5%, Prilocaine 2.5% #120gm – Apply 1gm three to four times daily for treatment of pain If Checked, Discuss Urea Usage
2. ____ CMPD Topical Cream – Gabapentin 3%, Diclofenac Sodium 1.5%, Lidocaine 2.5%, Prilocaine 2.5% #120gm – Apply 1gm three to four times daily for treatment of pain
3. ____ Celecoxib 400mg Cap #90 – Take one capsule by mouth once daily ***NSAID***
4. ____Pantoprazole 40mg Tab #90 – Take one tab by mouth once daily ***PPI – STOMACH ACID***

REFILLS (REFERS TO ALL MEDICATIONS PRESCRIBED ABOVE)

____ 1 Year ____ 5 ____ 3 ____ 1 ____ Zero

Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
DEA: _____ NPI: _____

_____ _____
Physician's Signature Date

As always, the FDA does not review any compounded medication for safety or efficacy.