

Physician's Medication Order Form: Scar Treatment



LIBERTY DRUG

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PHYSICIAN NAME: _____ DEA# _____ NPI# _____

PHYSICIAN ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHYSICIAN PHONE: _____ PHYSICIAN FAX: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Pracasil Plus

DIRECTIONS:

Apply to affected area twice a day

Other:

DIRECTIONS:

PATIENT NAME: _____ GENDER: _____ DOB: _____

PATIENT ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

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