Date:_____

CALL (706)-778-4918 WITH ANY QUESTIONS

Patient's Name:	**Prescriber's Name:**
Street Address:	Street Address:
City, State ZIP:	City, State ZIP:
Date of Birth:	Office #:
Phone #:	Fax #:
Additional Contact #:	Patient Allergies:

Substitution permitted: X _____ **DAW: X** _____

ANTI-INFECTIVE SKIN

1. _____ Ceftriaxone 500mg Vial #120 (2 Vials Equals One Dose as Defined Below)
   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. _____ Cefixime 400mg Cap #60
      ii. _____ Cefdinir 300mg Cap #60

Directions: (Directions indicated here refers to all medications prescribed above and below)

_____ **BASSA-GEL™** – Mix 1 dose with BASSA-GEL™, apply to affected areas twice daily

_____ **POWDER** – Empty 1 dose directly onto affected areas twice daily

_____ **SOLUTION** – Mix 1 dose and diluent, apply to affected areas twice daily

REFILLS (REFERS TO ALL MEDICATIONS PRESCRIBED ABOVE)

____ 1 Year ____ 5 ____ 3 ____ 1 ____ Zero

Information on Bassa-Gel™ being used with various anti-infective medications can be found by scanning this QR-Code or going to www.bassagel.com.

FAX FORM TO:
(706)-776-2502