QUICK ORDER FORM (DERMATOLOGY & PEDIATRIC)

Patient Full Name: _____ Patient DOB: _____ Date: _____

Patient Address: _____ City: _____ State: _____ Zip code: _____

DERMATOLOGY

·☐ **Morning Anti-Aging Cream (Hyaluronic Acid 1%/Snap-8 10%/Alpha Lipoic Acid 2%):**
Qty#: _____grams Sig: Apply to the face and neck every morning. Refills: _____

·☐ **Post Treatment Cream (Hyaluronic Acid 1%/Ceramides X Blend 1%)**:
Qty#: _____grams Sig: Apply to treatment area twice daily for 2 weeks. Refills: _____

·☐ **Rosacea Gel (Ivermectin 2%/Niacinamide 4%/Metronidazole 2%):**
Qty#: _____grams Sig: Apply to the affected areas sparingly every night at bedtime. Refills: _____

·☐ **Rosacea Cream (Ketoconazole 2%/Permethrin 5%):**
Qty#: _____grams Sig: Apply to the affected areas sparingly every night at bedtime. Refills: _____

·☐ **Under Eye Brightening Gel (Caffeine 3%/Vitamin K 1%/Vitamin E 1%/Ascorbyl Palmitate 3%)**:
Qty#: _____grams Sig: Apply to the affected areas every night at bedtime. Refills: _____

DERMATOLOGY - ACNE

·☐ **Clindamycin Phosphate 2%/Niacinamide 4%/Benzoyl Peroxide 5% Cream:**
Qty#:_____grams Sig: Apply on the affected areas every night at bedtime. Refills: _____

·☐ **Azelaic Acid 15%/Clindamycin 2%/Niacinamide 4% Cream**:
Qty#: _____grams Sig: Apply on the affected areas of the face every night at bedtime. Refills: _____

·☐ **Benzoyl Peroxide 3%/Clindamycin 1%/Niacinamide 4% Cream**:
Qty#: _____grams Sig: Apply on the affected areas of the face every night at bedtime. Refills: _____

·☐ **Clindamycin 2%/Salicylic Acid 3% Cream**:
Qty#: _____grams Sig: Apply to the affected areas of the face every night at bedtime. Refills: _____

·☐ **Azelaic Acid 5%/Clindamycin 2% Cream:**
Qty#: _____grams Sig: Apply to the affected areas every night at bedtime. Refills: _____

·☐ **Benzoyl Peroxide 4%/Salicylic Acid 4% Wash (mL) or Cream (g) (circle one):** Qty#: _____grams/mL
Sig: Apply to the face every night at bedtime. ·☐Use to wash face twice daily. Refills: _____

·☐ **Azelaic Acid 15%/Sulfacetamide 10%/Sulfur 5% Lotion (mL) or Cream (g) (circle one):**
Qty#: _____ **mL** or **g** (circle one) Sig: Apply on face once to twice daily. Refills: _____

PEDIATRIC

·☐ **Diaper Rash #1 (Cholestyramine Light 10%/Zinc Oxide 10% Ointment) Add Nystatin 10%? Yes or No (circle one)**
Qty#: _____grams Sig: Apply to the affected areas as needed. Refills: _____

·☐ **Diaper Rash #2 (Cholestyramine Light _____% (WRITE-IN Strength) in Aquaphor)**:
Qty#: _____grams Sig: Apply topically to the affected area after each diaper change prn. Refills: _____

·☐ **Sore Throat Lollipops (Circle one) Tetracaine 0.5% or Lidocaine 0.5% or Tetracaine 0.5%/Lidocaine 0.5%)**:
Qty#: _____ Sig: Dissolve 1 lollipop by mouth as needed for sore throat. Refills: _____

·☐ **Ondansetron 4mg/0.1mL or 8mg/0.5mL (circle one)** Qty#: _____mL
Sig: Give _____mL by mouth every _____ hours. Refills: _____

·☐ **All Purpose Nipple Ointment (Mupirocin 2%/Betamethasone 0.1%/Miconazole 2%)**
Sig: Apply sparingly topically to the affected areas after each feeding. Qty# (circle one) 30g 60g Refills: _____

Physician Name: _____ NPI or DEA: _____

Office Address: _____ Office Phone Number: _____

Signature: _____