



## PRESCRIPTION REQUEST FORM - EQUINE

### PATIENT INFORMATION

Animal Name: \_\_\_\_\_ Species/Breed: \_\_\_\_\_ Age: \_\_\_\_\_  
 Owner/Client Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

### R<sub>x</sub> COMPOUND PRESCRIPTION (drug name/strength)

### DOSAGE FORM (choose one)

- Oral Paste
- Oral Powder (Scoop)
- Oral Powder (Packs)
- Oral Suspension
- Topical Gel
- Topical Spray
- Shampoo
- Transdermal Cream
- Other \_\_\_\_\_

### Flavoring? Yes / No

- Apple       Cherry
- Molasses       Banana
- Peppermint       \_\_\_\_\_

Quantity: \_\_\_\_\_

Refills: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber Name \_\_\_\_\_ NPI# \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

### PAYMENT INFORMATION

- Contact **patient** for payment information.
- Bill **practice**.

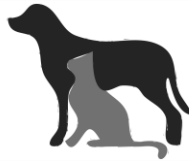
Please complete payment information below. A member of our staff will call you with the final price prior to authorizing.

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 Credit Card Number (Visa/MasterCard/Discover)      Expiration Date      Security Code

\_\_\_\_\_  
Name on Card

\_\_\_\_\_  
Authorized Signature

**Please FAX completed prescription order to WeCare Pharmacy at 540-878-2487.**



## PRESCRIPTION REQUEST FORM – SMALL ANIMAL

### PATIENT INFORMATION

Patient/Pet Name: \_\_\_\_\_ Species/Breed: \_\_\_\_\_ Age: \_\_\_\_\_  
Owner/Client Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

### R<sub>x</sub> COMPOUND PRESCRIPTION (drug name/strength)

#### DOSAGE FORM (choose one)

- Pet Tabs       Transdermal  
 Soft Chews     Shampoo  
 Tablets  
 Capsules  
 Suspension

#### Flavoring? Yes / No

- Chicken       Grape  
 Bacon         Strawberry  
 Tuna          Tutti Fruity  
 Beef

Quantity: \_\_\_\_\_

Refills: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber Name \_\_\_\_\_ NPI# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

### PAYMENT INFORMATION

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 Bill **practice**.

Please complete payment information below. A member of our staff will call you with the final price prior to authorizing.

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Credit Card Number (Visa/MasterCard/Discover)      Expiration Date      Security Code

\_\_\_\_\_  
Name on Card

\_\_\_\_\_  
Authorized Signature

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