YOUR HEALTH PHARMACY

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Patient Assessment Request (PAR)

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:_____

TYPE OF INFECTION

_____ Nasal _____ Wound _____ Nail Focused (Includes Penetrant)

_____ Lung _____ Skin Infection _____ Oral (Rinse/Wash)

_____ Thick-Scaly Skin (Urea Usage) _____ Otic – Ear Drum Perforation? ____ Yes ____ No ____ Unknown

_____ Dermatitis Diagnosis and/or Condition: _____ Cellulitis _____ Psoriasis _____ Eczema _____ Other

_____ Other: _____

PRESCRIBERS DESIRED MEDICATIONS (CHECK ALL APPLICABLE)

Antibiotic Coverage _____ Broad Spectrum _____ Gram Negative _____ Gram Positive

_____ Antifungal _____ Steroid _____ Acetylcysteine _____ Azelastine

DESCRIPTION OF WOUND IF APPLICABLE

_____ Wet _____ Dry _____ Optimal Location: _____ Size: _____

Desired Treatment Option: _____ RPh Suggestion/No Preference _____Powder _____Gel _____Spray

_____ Pain at Infection Site _____ Collagenase Inclusion

TREATMENT GOAL(S)

_____ Eradicate Infection _____ Reduce Pain _____ Reduce Inflammation

_____ Other: _____

If Available, Please Include ALL Patient Demographics, Clinic Notes and Organism Identification

Additional Information:

_____

_____

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

_____ _____
Physician's Signature Date

FDA does not review any compounded medication for safety/efficacy. CMPD refers to a compounded med.