

Urology Prescription Form (Part 1)

 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: _____

Compounded Penile Injections	ED Treatment Accessories	Libido & Orgasm Aids
<p>Tri-Mix Injections:</p> <p><input type="checkbox"/> 1 ml <input type="checkbox"/> 5 ml vial</p> <p><input type="checkbox"/> Half Strength PGE1 2.9mcg /Papaverine 8mg /Phentolamine 0.29mg per ml</p> <p><input type="checkbox"/> Standard PGE1 5.9mcg /Papaverine 17.59mg /Phentolamine 0.59mg per ml</p> <p><input type="checkbox"/> Plus PGE1 10mcg /Papaverine 30mg /Phentolamine 1mg per ml</p> <p><input type="checkbox"/> Double Strength (DS) PGE1 20mcg /Papaverine 30mg /Phentolamine 2mg per ml</p> <p><input type="checkbox"/> Super Plus PGE1 50mcg /Papaverine 30mg /Phentolamine 1.5mg per ml</p> <p>Custom Injection 5 ml</p> <p><input type="checkbox"/> PGE1 _____ mcg</p> <p><input type="checkbox"/> Papaverine _____ mg</p> <p><input type="checkbox"/> Phentolamine _____ mg</p> <p><input type="checkbox"/> Atropine _____ mg</p> <p><input type="checkbox"/> Lidocaine _____ mg per ml</p>	<p><input type="checkbox"/> STARTER KIT: (Includes)</p> <ul style="list-style-type: none"> • Syringes #10 • Alcohol Swabs #100 • Sharps Container • Pseudoephedrine 30 mg #24 (SIG: Use As Directed) <p><input type="checkbox"/> AUTO-INJECTOR Device</p> <p><input type="checkbox"/> Vacuum Erection Device</p> <p><input type="checkbox"/> Constriction Ring Kit</p> <p><input type="checkbox"/> Penile Rehab Protocol: (Includes)</p> <ul style="list-style-type: none"> • Consultation with Pharmacist • Vacuum Erection Device • Tadalafil 5 mg tab – 1 tab po qd #30 PRN refills • Nitric Oxide Booster Supplement <p><input type="checkbox"/> SYRINGES</p> <p><input type="checkbox"/> Sharps Container</p> <p><input type="checkbox"/> Pseudoephedrine 30mg tabs #24 SIG: Chew 3-4 tabs PO PRN prolonged erection. After 60 minutes if no improvement go to ER</p> <p><input type="checkbox"/> Phenylephrine HCL 10 mg/ml 1ml vial - Inject 0.05 ml - 0.1 mL Intracavernosally Priapism - As Directed # _____ vials</p>	<p><input type="checkbox"/> Oxytocin 50 IU SL Tablet</p> <p><input type="checkbox"/> Tadalafil 20 mg/Oxytocin 50 IU SL Tablet</p> <p>SIG: Dissolve 1 -2 tabs SL 30 – 60 minutes prior to sex</p> <p>Dispense: _____ Refills: _____ or PRN</p> <hr/> <p><input type="checkbox"/> Alprostadil 500 mcg/0.2ml Cream Apply 2 – 4 clicks (0.1 – 0.2 ml) onto the frenulum 15 – 30 minutes prior to sexual activity</p> <p>Dispense: _____ gm Refills: # _____ or PRN</p> <hr/> <p><input type="checkbox"/> Climax Control/Delay Spray -otc</p>

Directions: Inject 0.1 ml into the side of the penis to start **Refills: # _____ or PRN**

(Alternative SIG): _____

<p>ED Sublingual Troches/RDTs:</p> <p><input type="checkbox"/> Sildenafil 150 mg Sublingual Troche/RDT</p> <p><input type="checkbox"/> Tadalafil 75 mg Sublingual Troche/RDT</p> <p><input type="checkbox"/> Sildenafil 100 mg/Tadalafil 40 mg Sublingual Troche/RDT</p> <p><input type="checkbox"/> Vardenafil 75 mg Sublingual Troche/RDT</p> <p><input type="checkbox"/> Vardenafil 40 mg/Tadalafil 40 mg Sublingual Troche/RDT</p> <p style="padding-left: 20px;"><input type="checkbox"/> SIG: Dissolve (circle) ¼ ½ ¾ 1 troche/RDT SL PRN</p> <p style="padding-left: 20px;"><input type="checkbox"/> # _____ troches/RDT Refills: # _____ or PRN</p> <p><input type="checkbox"/> Tadalafil 20 mg Sublingual Troche/RDT</p> <p style="padding-left: 20px;"><input type="checkbox"/> SIG: Dissolve ¼ troche/RDT SL QD</p> <p># _____ troches/RDT Refills: # _____ or PRN</p>	<p><input type="checkbox"/> Tadalafil Plus Caps (2.5 mg Tadalafil/Nitric Oxide supplement)</p> <p style="padding-left: 20px;"><input type="checkbox"/> SIG: Take 1 cap by mouth BID</p> <p># _____ tablets Refills: # _____ or PRN</p> <p><input type="checkbox"/> Sildenafil 20 mg 50 mg 100 mg tablets (circle)</p> <p style="padding-left: 20px;"><input type="checkbox"/> SIG: Take # _____ tabs po prior to sexual activity</p> <p style="padding-left: 20px;"><input type="checkbox"/> Other: _____</p> <p># _____ tablets Refills: # _____ or PRN</p> <p><input type="checkbox"/> Tadalafil 5 mg 10 mg 20 mg tablets (circle)</p> <p style="padding-left: 20px;"><input type="checkbox"/> SIG: Take # _____ tabs po prior to sexual activity</p> <p style="padding-left: 20px;"><input type="checkbox"/> SIG: Take 1 tablet QD</p> <p># _____ tablets Refills: # _____ or PRN</p>
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*** (Prescriber's initials) _____** I am prescribing these compounds because they are clinically necessary for the treatment of this patient

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

 Physician's Signature

 Date
