

**Patient Information:** PLEASE FAX: Patient Demographic Sheet & Prescription Insurance Card if available.

LAST NAME:

DATE OF BIRTH:

PRIMARY PHONE #:

SECONDARY PHONE #:

DRIVER'S LICENSE (if CII, CIII or CIV):

ADDRESS:

CITY, STATE, ZIP:

ALLERGIES:

**Rx Medication Order:** Pharmacist Please Compound:

*Prescriber: You may change the directions, or delete / substitute / add any additional medications for all formulations.*

**Weight Loss and Methylation Injection Rx Form**

MIC Injection:

Methionone 25mg/Inositol 50mg/Choline 50mg/ml

1ml vials quantity: \_\_\_\_\_ refills: \_\_\_\_\_

Directions: Inject 1ml IM (intramuscular) twice weekly.

MIC Injection plus B-12

Methionone 15mg/Inositol 50mg/Choline 100mg/Methylcobalamin 100mcg/ml

1ml vials quantity: \_\_\_\_\_ refills: \_\_\_\_\_

Directions: Inject 1ml IM (intramuscular) twice weekly.

Methylcobalamin 25mg/ml injection

Prefilled syringes 0.3ml

quantity \_\_\_\_\_ refills \_\_\_\_\_

Directions: Inject 0.3cc (one syringe) subcutaneous every 3 days.

Emla Cream (tm) Lidocaine/Prilocaine 2.5% 2.5%

30gms refill: \_\_\_\_\_

Directions: Apply small amount to area of injection 1 hour prior.

(OPTIONAL) ADDITIONAL INSTRUCTIONS OR COMPOUNDS:

**Prescriber Information:**

PRESCRIBER'S SIGNATURE:

NPI# or DEA# (CTP# for CNPs only): DATE:

**Contact Information:**