CLARK
PROFESSIONAL PHARMACY
Intergrative Pharmacy Since 1980

Prescription Order Form

Please Fax to: (734) 585-5184 or Call in to: (734) 369-8782

3280 Washtenaw Ave. Suite B, Ann Arbor, MI 48104

PCAB ACCREDITED Compounding Pharmacy

Patient Information:

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

FIRST NAME:	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.

☐ **Low-dose Naltrexone 1.5 mg**

Dispense: 30 caps 90 caps ____caps

Refills: _____

SIG

☐ Day 1- 7: Take 1 capsule by mouth, at bedtime, once a day for 7 days

Day 8-14: Take 2 capsules by mouth, at bedtime, once a day for 7 days

Day 15 and after: Take 3 capsules by mouth, at bedtime, once a day for maintenance. (May change dosage to 4.5 mg capsules)

☐ Take 1 capsule by mouth, once a day, at bedtime.

☐ **Low-dose Naltrexone 3 mg**

Dispense: 30 caps 90 caps ____caps

Refills: _____

SIG

☐ Take 1 capsule by mouth, once a day at bedtime.

☐ **Low-dose Naltrexone 4.5 mg**

Dispense: 30 caps 90 caps ____caps

Refills: _____

SIG

☐ Take 1 capsule by mouth, once a day at bedtime.

(OPTIONAL) ADDITIONAL INSTRUCTIONS OR COMPOUNDS:

Prescriber Information:

PRESCRIBER'S SIGNATURE:

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

Contact Information: