LETTER OF PROTECTION/LIENS SCRIPT PAD

Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

Patient Name:_____ DOB:_____ Weight:_____ ☐ Male ☐ Female
Street Address:_____
Apt #:_____ City:_____ State:_____ Zip:_____
Phone: _____ Cell:_____
Attorney:_____ DOI:_____
Phone:_____ Fax:_____

Bill to: ☐ Attorney ☐ PIP (Personal Injury Protection)

PRESCRIPTION

☐ Cyclobenzaprine ☐ 5mg ☐ 10mg	SIG:	1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Amitriptyline ☐ 25mg ☐ 50mg	SIG:	1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Ibuprofen ☐ 800mg ☐ 600mg	SIG:	1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Naproxen ☐ 375mg ☐ 500mg	SIG:	1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Gabapentin ☐ 300mg ☐ 400mg ☐ 600mg	SIG:	1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Tizanidine ☐ 2mg ☐ 4mg	SIG:	1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Methocarbamol ☐ 500mg ☐ 750mg	SIG:	1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Diclofenac Sodium ☐ 75mg ☐ 50mg	SIG:	1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Omeprazole ☐ 20mg ☐ 40mg	SIG:	1	2	3	TAB	PO	QD	BID		QTY:_____ Refills_____
☐ Ranitidine ☐ 150mg ☐ 300mg	SIG:	1	2	3	TAB	PO	QD	BID		QTY:_____ Refills_____
☐ Meloxicam ☐ 7.5mg ☐ 15mg	SIG:	1	2	3	TAB	PO	QD	BID		QTY:_____ Refills_____
☐ Citalopram ☐ 20mg ☐ 40mg	SIG:	1	2	3	TAB	PO	QD			QTY:_____ Refills_____
☐ Medrol Dose Pack	SIG:	Use As Directed on package								
☐ Prednisone 10mg	SIG:_____									QTY:_____ Refills_____
☐ Capsaicin 0.025% 60gm	SIG:_____									QTY:_____ Refills_____
☐ Salonpas Patch	SIG:_____									QTY:_____ Refills_____

℞

ALL controlled substance quantities must be hand written in number and letter form

Prescriber's Name:_____ Office Contact:_____
Street Address:_____ Suite #:_____
City:_____ State:_____ Zip:_____ Tel:_____
License #:_____ NPI #:_____ DPS #:_____ DEA #:_____

Prescriber's Signature (signature required. NO STAMPS) _____ Date:_____

Please fax completed form to 1 (888) 294-9434