

IRRIGATIONS:

<input type="checkbox"/> Amphotericin-B Sig: Irrigate sinuses with 16ml through each nostril twice daily. Disp Qty: 2000 ml Antifungal agent	<input type="checkbox"/> Itraconazole (Sporonox) Sig: Irrigate sinuses with 16ml through each nostril twice daily. Disp Qty: 2000 ml Antifungal agent	<input type="checkbox"/> Gentamicin Sig: Irrigate sinuses with 16ml through each nostril twice daily. Disp Qty: 2000 ml Antibiotic	<input type="checkbox"/> Mupirocin Sig: Irrigate sinuses with 16ml through each nostril twice daily. Disp Qty: 1000 ml Antibiotic	<input type="checkbox"/> Vancomycin Sig: Irrigate sinuses with 16ml through each nostril twice daily. Disp Qty: 2000 ml Antibiotic									
<table border="1"><tr><td>200mg</td></tr><tr><td>400mg</td></tr><tr><td>600mg</td></tr></table>	200mg	400mg	600mg	<table border="1"><tr><td>200mg</td></tr><tr><td>400mg</td></tr></table>	200mg	400mg	<table border="1"><tr><td>160mg</td></tr></table>	160mg	<table border="1"><tr><td>0.1%</td></tr><tr><td>0.2%</td></tr></table>	0.1%	0.2%	<table border="1"><tr><td>600mg</td></tr></table>	600mg
200mg													
400mg													
600mg													
200mg													
400mg													
160mg													
0.1%													
0.2%													
600mg													

NASAL SPRAYS:

<input type="checkbox"/> Amphotericin-B Sig: Spray 5 times into each nostril twice daily. Disp Qty: #1 x 60 ml Antifungal agent	<input type="checkbox"/> Itraconazole (Sporonox) Sig: Spray 5 times into each nostril twice daily. Disp Qty: #1 x 60 ml Antifungal agent	<input type="checkbox"/> Fluconazole / Gentamicin Sig: Spray 5 times into each nostril twice daily. Disp Qty: #1 x 60 ml Antifungal agent/Antibiotic	<input type="checkbox"/> Moxifloxacin (Avelox) Sig: Spray 2 times into each nostril twice daily. Disp Qty: #1 x 30 ml Antibiotic							
<table border="1"><tr><td>6mg</td></tr><tr><td>12mg</td></tr><tr><td>18mg</td></tr></table>	6mg	12mg	18mg	<table border="1"><tr><td>60mg</td></tr><tr><td>120mg</td></tr></table>	60mg	120mg	<table border="1"><tr><td>12mg/20mg</td></tr></table>	12mg/20mg	<table border="1"><tr><td>48mg</td></tr></table>	48mg
6mg										
12mg										
18mg										
60mg										
120mg										
12mg/20mg										
48mg										
<input type="checkbox"/> Tobramycin / Clindamycin Sig: Spray 5 times into each nostril twice daily. Disp Qty: #1 x 60 ml Antibiotic	<input type="checkbox"/> Mupirocin Sig: Spray 5 times into each nostril twice daily. Disp Qty: #1 x 60 ml Antibiotic	<input type="checkbox"/> Vancomycin Sig: Spray 5 times into each nostril twice daily. Disp Qty: 60 ml Antibiotic	<input type="checkbox"/> Dexamethasone Sig: Spray 2 times into each nostril twice daily. Disp Qty: #1 x 30 ml Steroid							
<table border="1"><tr><td>20mg/150mg</td></tr></table>	20mg/150mg	<table border="1"><tr><td>0.1%</td></tr><tr><td>0.2%</td></tr></table>	0.1%	0.2%	<table border="1"><tr><td>300mg</td></tr></table>	300mg	<table border="1"><tr><td>30mg</td></tr></table>	30mg		
20mg/150mg										
0.1%										
0.2%										
300mg										
30mg										

****Dexamethasone 2 fill limit****
3rd fill must be approved by a physician**

Prescriptions based on 30 day supply.

** Refill: 1 2 3 4 5 PRN

Diagnosis: _____

Allergies: _____

Home Care Solutions Pharmacy will contact the patient and confirm the order.

Special Orders/Special Instructions: _____

PHYSICIAN NAME: _____ Physician Signature: _____

Office Telephone: _____ Fax: _____

NPI: _____ DEA#: _____ UPIN: _____ License: _____

Address: _____ Date: _____

Dispense as Written: _____ Generic Substitute: _____

PATIENT NAME: _____ Date of Birth: _____

Telephone: _____ Work: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

