Drug Name:	
Drug Strength:	
Drug Form:	
Quantity:	
Refills:	
Instructions:	

Doctor Signature_____ Date: ____/____/____

Patient Name:	
Patient Phone:	
Patient Address:	
City/State/Zip	
Doctor Name:	
Doctor Phone:	
Doctor Address:	
City/State/Zip	
DEA#:	
License Number:	

Please **print and FAX** to **630-859-0114**

All information will be verified prior to processing.
All patient information is considered confidential and is to be released only to authorized personnel, as delineated by HIPAA.