| PATIENT'S FULL NAME | PHONE NUMBER | AGE | SEX |
|---|---|---|---|
| ADDRESS | | DATE / / | |

℞

❑ *Dispense Only As Written* *Dr.* ______________________

❑ *Refills 1 2 3 4* __________ *DEA #:* ______________________
❑ *No Refills Void After* __________

**VALID FOR CONTROLLED SUBSTANCES**

Standard Register