

Andrews Apothecary

Gastro 2 of 2 form

3072-A Trenwest Drive, Winston Salem, NC 27103
phone 336-723-1679 Please Fax to: 336-723-1670

Patient name: _____ Date of Birth: _____

Best phone number: _____ Email: _____

Street address: _____ City: _____ State: _____ Zip: _____

Allergies: _____

Form 2 of 2 for GAP

****Please circle desired formula number and circle or enter the desired quantity. No medical claims intended.****

1	Sucralfate 2gm/20ml Enema Disp _____ x20ml Enemas	Sig: Administer contents of 1 enema rectally _____ x daily x _____ days
2		
3	Promethazine 25mg/0.1ml transdermal Disp _____ x 1ml syringes	Sig: Apply 0.1ml (25mg) to wrist and rub in well q4-6h prn
4		
5	Ondansetron 4mg/0.1ml transdermal Disp: _____ x1ml syringes	Sig: Apply 0.1ml (4mg) to wrist and rub in well q6-8h prn
6		
7	Lansoprazole susp 3mg/ml Disp _____ ml	Sig: Take _____ ml po _____
8		

Additional comments or formulations:

Refills (circle one): 0 1 2 3 4 5 6 PRN

Prescriber name printed here please _____ Signature here: _____
Today's date: _____

THIS FORM PROVIDED AT THE REQUEST OF THE PRESCRIBER

Please email us at refills@andrewsapothecary.com with your practice info as you would like for it to appear and we will gladly make the edit for you and email back a clean copy. Please attach the fax form that you want so that we can be sure to get you what you need.