



Publix Compounding Pharmacy #3212
TOPICAL REFERRAL FORM

2424 Orlando Central Parkway,
 Suite 200
 Orlando, FL 32809
 Phone: 877-253-8949
 Fax: 407-965-4390

Commercially available products may not be compounded unless there is a documented allergy/intolerance to commercial product.
Please include this documentation as necessary.

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/___ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone Number: (____) _____ Alt. Phone Number: (____) _____ Allergies: NKDA Other: _____

PRODUCT	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
<input type="checkbox"/> Lidocaine 1.5%, Nifedipine 0.3% <input type="checkbox"/> Lidocaine 3%, Nifedipine 0.5% <input type="checkbox"/> Lidocaine 3%, Diltiazem 2%, Hydrocortisone 2.5% <u>Substitutions</u> <input type="checkbox"/> Lidocaine 1.5%, Prilocaine 1.5%, Diltiazem 2% <input type="checkbox"/> Lidocaine 1.5%, Diltiazem 2%	Apply pea sized amount to the affected area(s) 2-3 times daily as directed. For external use only. Other: _____ Please pick one: <input type="checkbox"/> Cream <input type="checkbox"/> Gel <input type="checkbox"/> Ointment	<input type="checkbox"/> 30 gm <input type="checkbox"/> 60 gm <input type="checkbox"/> 90 gm <input type="checkbox"/> Other: _____ gm	_____
<input type="checkbox"/> Nitroglycerin: <input type="checkbox"/> 0.1% <input type="checkbox"/> 0.2% <input type="checkbox"/> 0.3%	Apply pea sized amount to the affected area(s) 3-4 times daily as directed. For external use only. Please pick one: <input type="checkbox"/> Cream <input type="checkbox"/> Gel <input type="checkbox"/> Ointment	<input type="checkbox"/> 30 gm <input type="checkbox"/> 60 gm <input type="checkbox"/> 90 gm	_____
Please list strength of each ingredient selected: <input type="checkbox"/> Lidocaine: _____ % <input type="checkbox"/> Prilocaine: _____ % <input type="checkbox"/> Nifedipine: _____ % <input type="checkbox"/> Nitroglycerin: _____ % <input type="checkbox"/> Diltiazem: _____ % <input type="checkbox"/> Other: _____ + _____ %	Apply pea sized amount topically/rectally (please circle one) _____ time(s) a day (Please pick one) Topically: <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> Other: _____ Rectally: <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> Other: _____ (Please pick one) <input type="checkbox"/> Cream <input type="checkbox"/> Rectal tip <input type="checkbox"/> Patient to apply with gloved finger <input type="checkbox"/> Gel <input type="checkbox"/> Ointment	<input type="checkbox"/> 30 gm <input type="checkbox"/> 60 gm <input type="checkbox"/> 90 gm <input type="checkbox"/> Other: _____ gm	_____

* Pea sized = Approximately 0.5 grams

Comments for RPh:

Prescriber Information

Name: _____ DEA# _____ NPI # _____
 Address: _____ City: _____ State: _____ Zip: _____
 Office Phone Number: (____) _____ Fax Number: (____) _____ Office Contact: _____

Prescriber's signature: _____
 (stamps not accepted) Substitution allowed Date Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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Please fax completed forms and all necessary documents to (407)-965-4390