



**Publix Compounding Pharmacy #3212**  
MOUTHWASH REFERRAL FORM

7616 Southland Blvd, Suite 112  
Orlando, FL 32809  
Phone: 877-253-8949  
Fax: 407-965-4390

**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: (\_\_\_\_) \_\_\_\_\_ Caregiver name: \_\_\_\_\_  
Allergies: NKDA Other: \_\_\_\_\_

*\*All liquid-containing mouthwash can be prepared at patient's local Publix.\*  
\* Tablet/Powder-containing mouthwash will be shipped from the Compounding facility to patient's home. \**

FORMULA	DIRECTIONS	TOTAL QTY/ DS	REFILLS
<b><u>Basic Magic Mouthwash:</u></b> <i>(equal parts; 1:1:1)</i> Diphenhydramine 12.5 mg/5 ml Maalox Lidocaine 2%	Swish & Swallow/Spit (Please circle one) _____ ml _____ time(s) per day	_____	_____
<b><u>Duke's Magic Mouthwash:</u></b> Diphenhydramine 12.5 mg/5ml Hydrocortisone 60 mg Nystatin 30 ml (30 million units)	Swish & Swallow/Spit (Please circle one) _____ ml _____ time(s) per day	_____	_____
<b><u>Gator Swish:</u></b> Diphenhydramine 12.5mg/5 ml Doxycycline 1500 mg Hydrocortisone 60 mg Nystatin 60 ml (6 millions units)	Swish & Swallow/Spit (Please circle one) _____ ml _____ time(s) per day	_____	_____
<b><u>Mile's Solution:</u></b> Diphenhydramine 12.5 mg/5ml Hydrocortisone 100 mg Tetracycline 2 gm Nystatin suspension 20 ml (2 million units) Lidocaine 2%	Swish & Swallow/Spit (Please circle one) _____ ml _____ time(s) per day	_____	_____
<b><u>Custom Formula:</u></b> <i>(please include strength &amp; quantity for each ingredient)</i> _____ _____ _____ _____ _____	Swish & Swallow/Spit (Please circle one) _____ ml _____ time(s) per day	_____	_____

Comments for RPh: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRESCRIBER INFORMATION**

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

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

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**