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
☐ **Basic Magic Mouthwash:** *(equal parts; 1:1:1)* Diphenhydramine 12.5 mg/5 ml Maalox Lidocaine 2%	Swish & Swallow/Spit (Please circle one _____ ml _____ time(s) per day	_____	_____
☐ **Duke's Magic Mouthwash:** 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	_____	_____
☐ **Gator Swish:** Diphenhydramine 12.5mg/5 ml Doxycycline 1500 mg Hydrodcortisone 60 mg Nystatin 60 ml (6 millions units)	Swish & Swallow/Spit (Please circle one) _____ ml _____ time(s) per day	_____	_____
☐ **Mile's Solution:** 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	_____	_____
☐ **Custom Formula:** *(please include strength & quantity for each ingredient)* _____ _____ _____ _____ _____	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: _____ _____
(stamps not accepted) ☐ Substitution allowed Date ☐ Dispense as written/ Do not substitute Date

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

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