TrueMed LLC

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FAXED PRESCRIPTIONS ARE TO BE SENT TO THE INFORMATION BELOW
Fax: 214-286-5354

PATIENT INFORMATION

PATIENT NAME:	DATE OF BIRTH:
PATIENT PHONE:	GENDER: MALE FEMALE
ADDRESS:	PREGNANT: YES NO
CITY, ST, ZIP:	DRUG ALLERGY:

PROVIDER INFORMATION

PROVIDER NAME:	PROVIDER PHONE:
ADDRESS:	PROVIDER FAX:
CITY, ST, ZIP:	NPI:

LAW FIRM INFORMATION

LAW FIRM NAME:	CASE MANAGER:
DATE OF INJURY:	EMAIL:
ADDRESS:	PHONE:
CITY, ST, ZIP:	FAX:

ORDERS

NSAIDS

____ Meloxicam 7.5MG QTY# ____ SIG_____
____ Meloxicam 15MG QTY# ____ SIG_____
____ Naproxen 500MG QTY# ____ SIG_____
____ Ibuprofen 400MG QTY# ____ SIG_____
____ Ibuprofen 600MG QTY# ____ SIG_____
____ Ibuprofen 800MG QTY# ____ SIG_____

MUSCLE RELAXANTS

____ Cyclobenzaprine 5MG QTY# ____ SIG_____
____ Cyclobenzaprine 10MG QTY# ____ SIG_____
____ Methocarbamol 500MG QTY# ____ SIG_____
____ Methocarbamol 750MG QTY# ____ SIG_____
____ Baclofen 10MG QTY# ____ SIG_____
____ Baclofen 20MG QTY# ____ SIG_____
____ Tizanidine 2MG QTY# ____ SIG_____
____ Tizanidine 4MG QTY# ____ SIG_____

TOPICALS

____ Lidocaine 5% Patch 30 Count SIG _____
____ Diclofenac 3% Gel 100GM Tube SIG _____

GI

____ Omeprazole 40MG QTY# ____ SIG_____
____ Pantoprazole 40MG QTY# ____ SIG_____

PROVDER SIGNATURE: _____ DATE: _____

COMMENTS: