PEDIATRIC PRESCRIPTION ORDER FORM

Please complete entire form and fax to Fusion Pharmacy at (435) 359-1300.

If you need to speak to someone at Fusion Pharmacy, call (435) 703-9680.

Date _____

PATIENT INFO

Name _____ Phone _____

Address _____ D.O.B. _____ Gender ❑ M ❑ F

City, State, Zip _____ Drug Allergies _____

Med. Cond. _____

PATIENT PRESCRIPTION

Environmental Starter Kit

- ❑ 0-12 months (6 vial build-up to 1:12,500 concentration), daily
- ❑ 12-36 months (7 vial build-up to 1:2,500 concentration), daily
- ❑ 3-6 years (8 vial build-up to 1:500 concentration), daily
- ❑ 7 years-adult (8 vial build-up to 1:500 concentration), daily

Food Starter Kit

- ❑ 0-12 months (6 vial build-up to 1:12,500 concentration), daily
- ❑ 12-36 months (7 vial build-up to 1:2,500 concentration), daily
- ❑ 3-6 years (8 vial build-up to 1:500 concentration), daily
- ❑ 7 years-adult (8 vial build-up to 1:500 concentration), daily

Environmental Maintenance Bottle

- ❑ 0-12 months (1:12,500 concentration 4 drops/pumps daily unless otherwise specified
- ❑ 12-36 months (1:2,500 concentration 4 drops/pumps daily unless otherwise specified
- ❑ 3-6 years (1:500 concentration 2 drops/pumps daily unless otherwise specified
- ❑ 7 years-adult (1:500 concentration 3 drops/pumps daily unless otherwiese specified

# of daily drops *(if different than above)*:____ **Refill Quantity:**____ *(3 max)*

Food Maintenance Bottle

- ❑ 0-12 months (1:12,500 concentration 4 drops/pumps daily unless otherwise specified
- ❑ 12-36 months (1:2,500 concentration 4 drops/pumps daily unless otherwise specified
- ❑ 3-6 years (1:500 concentration 2 drops/pumps daily unless otherwise specified
- ❑ 7 years-adult (1:500 concentration 3 drops/pumps daily unless otherwiese specified

# of daily drops *(if different than above)*:____ **Refill Quantity:**____ *(3 max)*

ADDITIONAL INSTRUCTIONS *(Please contact pharmacist for specific antigen requests)* : _____

_____

Ordering Physician's Signature _____

Print Physician's Name _____

PRESCRIBER INFO

NPI # (Required) _____ Clinic Name _____

Phone Number _____ Address _____

City, State, Zip _____

SHIP TO *Check One Box Only*

❑ Clinic ❑ Patient Name (of clinic or patient to ship to) _____

Street Address _____

City, State, Zip _____

BILL TO *Check One Box Only*

❑ Clinic ❑ Patient