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 (8-Vial Build-up to 1:500 Concentration) *As Directed*

❑ Environmental Maintenance Bottle (1:500 Concentration 3 Drops/Pumps Daily Unless Otherwise Specified)

Number of Drops Daily:_____ Refill Quantity: _____ (3 Max)

❑ Food Starter Kit (8-Vial Build-up to 1:500 Concentration) *As Directed*

❑ Food Maintenance Bottle (1:500 Concentration 3 Drops/Pumps Daily Unless Otherwise Specified)

Number of Drops Daily:_____ Refill Quantity: _____ (3 Max)

Boosts (for Environmental Maintenance Vials Only)

❑ Mountain Mix ❑ Mold Mix ❑ Pet Mix ❑ Insect Mix ❑ Spring Mix ❑ Summer Mix ❑ Fall Mix ❑ Winter Mix

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