For Fax Transmittal Only to Patients Choice of Pharmacy or Healthway Compounding Pharmacy at 989-791-4603

Healthway Compounding Pharmacy
2544 Mcleod Dr N Ste #2 • Saginaw, MI. 48604
Phone 989-791-1691 • Fax 989-791-4603

Patient:____________________ Owner____ Date__________

Address____________________________________ City/St./Zip____

Phone: (___)___________________________ Allergies:____

All compounds for clinical use require a written prescription for each individual patient. Medication will be dispensed in patient specific package and with patient specific label .

Commonly Requested Veterinary Formulations page 1 of 2

☐ Amitriptyline____mg Dispense:_____
- ☐ **Cream mg/0.1ml**
- ☐ **Flavored Liquid mg/ml**

☐ Cisapride____mg Dispense:_____
- ☐ **Cream mg/0.1ml**
- ☐ **Flavored Liquid mg/ml**

☐ Diazepam ____mg Dispense:_____
- ☐ **Suppository**
- ☐ **Flavored Liquid mg/ml**

☐ Doxycycline____mg Dispense:_____
- ☐ **Flavored Liquid mg/ml**

☐ Fluoxetine____mg Dispense:_____
- ☐ **Cream mg/0.1ml**
- ☐ **Flavored Liquid mg/ml**

☐ Methimazole ____mg Dispense:_____
- ☐ **Cream mg/0.1ml**
- ☐ **Flavored Liquid mg/ml**

☐ Metronidazole ____mg Dispense:_____
- ☐ **Capsule**
- ☐ **Flavored Liquid mg/ml**

☐ Potassium Bromide ____mg Dispense:_____
- ☐ **Capsule**
- ☐ Flavored Liquid mg/ml

☐ Phenylpropanolamine Dispense:_____
- ☐ **Capsule**

☐ Prednisolone ____mg Dispense:_____
- ☐ **Cream mg/0.1ml**
- ☐ **Flavored Liquid mg/ml**

SIG: ____
____
____

Refills_______

Prescriber Signature________________________________ Prescriber Name (Printed) ______________________________

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Saginaw, MI 48604

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Commonly Requested Veterinary Formulations page 2 of 2

☐ Otic Gel (Ciprofloxacin 2%/Ketoconazole 2%/ Triamcinolone 0.25%)

This is meant to be a one time treatment.

☐ 1.5 ml each or ☐ 4 ml each

For dogs less than 90 lbs, instill 1.5ml into each affected ear.

For dogs greater than 90 lbs, instill 4ml into each affected ear.

☐ Otic Powder (Boric Acid 25%/Clotrimazole 1%/)

☐ 10 gm in accordion puffer ☐ Other____gm

Sig: Puff 2 puffs into affected ear twice daily.

☐ Other________________________________

____

Refills_______

Prescriber Signature________________________________ Prescriber Name (Printed) ______________________________

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