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**

☐ Gabapentin ____mg Dispense:_____
- ☐ **Cream___ mg/0.1ml** ☐ **Flavored Liquid__ mg/ml**

Flavors– Beef, Chicken or Fish

☐ 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**

☐ Prazosin___mg Dispense:_____
- ☐ **Capsule** ☐ **Flavored Liquid__ mg/ml**

☐ Prednisolone ____mg Dispense:_____
- ☐ **Cream___ mg/0.1ml** ☐ **Flavored Liquid__ mg/ml**

SIG: _____
_____
_____

Refills_____

Prescriber Signature_____ Prescriber Name (Printed) _____

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Commonly Requested Veterinary Formulations

☐ Otic Gel (Ciprofloxacin 2%/Ketoconazole 2%/ Triamcinolone 0.25% F: 14118)

**Medication should be administered by veterinarian during office visit.
**Recommended repeat application 1 week after 1st dose.

☐ 3ml (1.5ml each visit) one ear ☐ 6ml (1.5ml each ear per visit) both ears

☐ 8ml (4ml each visit) one ear ☐ 16ml (4ml each ear per visit) both ears

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 aff ected ear twice daily.

☐ Other_____

_____

Refills_____

Prescriber Signature_____ Prescriber Name (Printed) _____

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