NABP Accredited Compounding Pharmacy

a daywel company
MILLERS
SINCE 1919

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HYDRALAST ORDER FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME: DATE of BIRTH (Month / Day)

_____/_____

PRIMARY PHONE #: ◯ CELL ◯ HOME ◯ WORK SECONDARY PHONE #: ◯ CELL ◯ HOME ◯ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

HYDRALAST MEDICATIONS

☐ **Sildenafil**

QUANTITY	STRENGTH	FLAVOR:
◯ 15	◯ 25mg	◯ Grape
◯ 30	◯ 50mg	◯ Lemon Tea
	◯ 100mg	◯ Pineapple Mango

☐ **Tadalafil**

QUANTITY	STRENGTH	FLAVOR:
◯ 15	◯ 5mg	◯ Grape
◯ 30	◯ 10mg	◯ Lemon Tea
	◯ 20mg	◯ Pineapple Mango

Refills: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ PRN ◯ NR SIG:_____

WRITE PRESCRIPTION / ADDITIONAL COMMENTS

DOCTOR PHONE NPI # DEA #

OFFICE MANAGER PHONE OFFICE FAX OFFICE Email

SIGNATURE DATE (Month / Day / Year)

_____/_____/_____