Prescription Referral Form

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

AssureRx PHARMACY
2026 Babcock Road, Suite # 104 • San Antonio- 78229, TX
Ph : 210.467.5174 • Fax: 210.467.5184 • www.AssureRxPharmacy.com

Date Medication Needed: _____ **Ship To:** ◯ Patient's Home ◯ Prescriber's Office ◯ Pick-up _____ Injection training by pharmacy?

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** Male Female **Height:** _____ **Weight:** _____ lbs. kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** _____ **Fax:** _____

City, State, Zip: _____ **Key Contact:** _____ **Phone:** _____

3: Prescription Information

_____ _____ %
Bupivacaine 1%
Clonidine 0.2%
Doxepin 5%
Gabapentin 6%

Sig. _____
Refill _____ NR
Quantity _____

_____ _____ %
Bupivacaine 1%
Carbamazeipine 3%
Doxepin 6%
Gabapentin 6%
Topiramate 1%

Sig. _____
Refill _____ NR
Quantity _____

_____ _____ %
Bupivacaine 1%
Diclofenac 3%
Doxepin 3%
Gabapentin 6%
Orphenadrine 5%

Sig. _____
Refill _____ NR
Quantity _____

Amantadine 8%
Bupivacaine 1%
Diltiazem 2%
Doxepin 3%
Gabapentin 6%
Orphenadrine 5%
Topiramate 2%

Sig. _____
Refill _____ NR
Quantity _____

_____ _____ %
Bupaivacaine 1%
Doxepin 3%
Gabapentin 6%
Ketorolac 0.5%
Ayclovir 5%

Sig. _____
Refill _____ NR
Quantity _____

_____ _____ %
Baclofen 2%
Bupivacaine 1%
Cylcobenzaprine 2%
Gabapentin 6%
Orphenadrine 5%

Sig. _____
Refill _____ NR
Quantity _____

Ketoprofen 10%
Ibuprofen 10%
Cylcobenzaprine 2%
Piroxicam 2%
Lidocaine 2%

Sig. _____
Refill _____ NR
Quantity _____

_____ _____ %
Bupivacaine 1%
Doxepin 3%
Gabapentin 6%
Nifedipine 2%

Sig. _____
Refill _____ NR
Quantity _____

Diclofenac 3%
Baclofen 2%
Bupivacaine 1%
Ibuprofen 3%

Sig. _____
Refill _____ NR
Quantity _____

Other

Sig. _____
Refill _____ NR
Quantity _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____