

Animal Name: _____ Species: _____
 Address: _____
 Phone: _____ Date: _____

<p><u>Transdermal Ear Gels</u></p> <p>___ Amitriptyline ___ mg/0.1ml ___ Cisapride ___ mg/0.1ml ___ Fluoxetine ___ mg/0.1ml ___ Methimazole ___ mg/0.1ml</p> <p>___ Other _____ mg/0.1ml</p> <p>Dispense: 1 month</p> <p>Sig: Apply 0.1ml ___ times per day</p>	<p><u>Suspensions</u></p> <p>___ Methimazole 2.5mg/ml ___ Methimazole 5mg/ml ___ Methimazole ___ mg/ml ___ Potassium Bromide 250mg/ml ___ Potassium Bromide 500mg/ml ___ Potassium Bromide ___ mg/ml ___ Cisapride ___ mg/ml</p> <p>___ Other _____ mg/ml</p> <p>Quantity: _____ ml</p> <p>Sig: Give ___ ml ___ times per day.</p> <p>Flavor: (circle one) Beef Catnip Cheese Chicken Fish Peanut Butter Shrimp</p>
<p><u>Capsules</u></p> <p>___ DES 1mg ___ Fludrocortisone ___ mg ___ Phenylpropanolamine ___ mg ___ Piroxicam ___ mg ___ Potassium Bromide ___ mg ___ Ursodiol ___ mg</p> <p>___ Other _____ mg</p> <p>Dispense: _____ capsules</p> <p>Sig: ___ capsules ___ times per day</p>	<p><u>Biscuits</u></p> <p>___ Etodolac ___ mg</p> <p>___ Other _____ mg</p> <p>Quantity: 1 month</p> <p>Sig: ___ biscuit(s) _____ times per day</p>

Refills: _____

Clinic Name: _____	
Address: _____	(Printed Physician Name)
City/State/Zip: _____	
Phone: _____	
Fax: _____	(Physician Signature)

Fax to Specialty Medicine Compounding Pharmacy at 248-486-1906.