



TOWN & COUNTRY
compounding | consultation



Foot Bath (Anti Infective) Order Form
ACHC Accredited Pharmacy
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Pharmacist@TCcompound.com

Patient's Name:	Prescriber's Name:
Street Address:	Street Address:
City, State ZIP:	City, State ZIP:
Date of Birth:	Office #:
Phone (CELL) #:	Fax #:
Email:	Email:
Patient Allergies:	

PRESCRIBER'S SIGNATURE: X _____ DATE: _____

Commonly Requested Medications: (Dispense Checked Medications as Authorized Below)

1. _____ **CMPD MUPIROCIN 25% / ITRACONAZOLE 25% in Loxasperse®-Xylifos™ Powder (RXT1775)**
 - a. If checked, pharmacy is authorized to dispense the following in lieu of the medication listed in #1 above if needed for any reason or desired by patient
 - i. _____ Mupirocin 2% Ointment 22gram Tube #30 tubes (660grams) and Nystatin Topical Powder 15 Gram Containers #30 containers (450grams) – add contents of one tube (22gms) of Mupirocin and one container (15gms) of Nystatin into mixing container, add provided diluent, shake, add solution to the foot-bath, allow to agitate, place feet in solution for 10 minutes – perform once daily (RX FBMUPI FBNYST)
 - ii. _____ CMPD Azithromycin 250mg / Fluconazole 200mg Capsule (RXT1776) # 30–Add contents of 1 capsule into mixing container, add provided diluent, shake, add solution to the foot-bath, allow to agitate, place feet in solution for 10 minutes – perform once daily (RX FBCAP1)

2. _____ **OTHER _____**

Directions (Directions selected below apply to all medications indicated above – unless otherwise indicated above)

- _____ Add 3 grams into mixing container, add provided diluent, shake, add solution to foot-bath, allow to agitate, place feet in solution for 10 minutes – perform once daily (RX FOOTBATH1)
- _____ Other _____

Quantity to Dispense: _____ **DAYS *30 DAY SUPPLY UNLESS OTHERWISE INDICATED HERE OR ABOVE***

Refills: (Number of refills indicated here refers to all medications prescribed above)

___ 1 Year ___ 5 ___ 3 ___ 1 ___ Zero