TOWN & COUNTRY
compounding | consultation

Gastro Order Form
ACHC Accredited Pharmacy
Phone: 201-447-2020
Fax: 201-447-3253
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 Compounds for Gastroenterologists:

1. _____ **Diltiazem 2% Cream** _____ **30 gm** _____ **60 gm**
   SIG: *Apply pea-sized amount to peri-anal area twice daily*

2. _____ **Nitroglycerin 0.2% Cream** _____ **30 gm** _____ **60 gm**
   SIG: *Apply pea-sized amount to peri-anal twice daily*

3. _____ **Nifedipine 0.2% Ointment** _____ **30 gm** _____ **60 gm**
   SIG: *Apply pea-sized amount to peri-anal twice daily*

4. _____ **Metronidazole 10% Ointment** _____ **100 gm** _____ **Other**
   SIG: _____

5. _____ **Rocket Lidocaine 2% - Hydrocortisone 1% Suppository** _____ **Qty.**
   SIG: *Insert one suppository at bedtime*

6. _____ **Nifedipine 0.2% Suppository** _____ **Qty.**
   SIG: *Insert one suppository at bedtime*

7. _____ **Diltiazem 3% Hydrocortisone 1% Lidocaine 2% Suppository** _____ **Qty.**
   SIG: *Insert one suppository at bedtime*

8. _____ **Naltrexone 4.5 mg Capsules (for Crohn's Disease)** _____ **Qty.**
   SIG: *Take 1 capsule by mouth at bedtime*

9. _____ **Naltrexone 0.5 mg Capsules (for IBS)** _____ **Qty.**
   SIG: *Take 1 capsule by mouth at bedtime*

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

____ 1 Year ____5 ____3 ____1 ____Zero