TOWN & COUNTRY
compounding | consultation

ACCREDITED
Compounding Pharmacy
A SERVICE OF ACHC

Foot and Nail Infection Order Form
ACHC Accredited Pharmacy
Direct Phone 201-447-2020
Direct Fax 201-447-3253
www.tccompound.com

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: (CMPD refers to medication compounded by pharmacy)

1. _____ CMPD OINTMENT DOXYCYCLINE 5%, MUPIROCIN 1.6%, KETOCONAZOLE 5%
2. _____ CMPD OINTMENT TOBRAMYCIN 7.5%, MUPIROCIN 1.775%
3. _____ CMPD OINTMENT DOXYCYCLINE 5%, MUPIROCIN 1.756%
4. _____ CMPD OINTMENT AZITHROMYCIN 5%, MUPIROCIN 1.8%
5. _____ OTHER _____
6. _____ CMPD OINTMENT KETOCONAZOLE 7.5%, MUPIROCIN 1.77%

For Nail Fungus:

7. _____ CMPD ITRACONAZOLE 1%, IBUPROFEN 2%, DMSO NAIL SOLUTION

Directions: (Directions selected below apply to all medications indicated above)

____ OINTMENT – Apply up to 4 grams to affected area(s) 2 times daily as directed

____ Other _____

Quantity to Dispense:_____DAYS *30 DAY SUPPLY UNLESS OTHERWISE INDICATED*

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

____ 5_____3_____1_____Zero