TOWN & COUNTRY
compounding | consultation

ACCREDITED
Compounding Pharmacy

Warts General 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 Medications: (CMPD refers to medication compounded by pharmacy)

1. ____CMPD Salicylic Acid 27% in solution brush on applicator
2. ____CMPD Salicylic Acid 20%, 5-FU 5% DMSO brush on applicator
3. ____CMPD Salicylic Acid 40% or_____% Ointment
4. ____CMPD Salicylic Acid 40% or_____%, 5-FU 5% in Emollient Cream
5. ____CMPD Flouroracil 5% Salicylic Acid 15%, Cimetidine 5%, Deoxy-D-Glucose 0.2% in Lipoderm™

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

_____ Apply to wart two times daily

_____ **OTHER**_____

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

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

_____ 1 Year ____5 ____3 ____1 ____Zero