



9550 South State Street Sandy, UT 84070

Phone: 1-833-633-4838

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PRESCRIPTION FAX FORM to be faxed by the practice only
ALL AREAS MUST BE COMPLETED FOR PROPER PROCESSING

Date: ____/____/____

Prescribing Doctor Name as it appears on License

License # _____ EXP: _____

DEA # _____ EXP: _____

Signature _____

Please Check Type of Order:

- Bill & Ship directly to Owner
- Clinic Order
- Drop Ship (Clinic pays/ships to owner)

CLINIC INFORMATION

Name _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ Email _____

OWNER INFORMATION

First Name _____ Last Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Driver's License # _____ State _____ Expiration Date _____ Date of Birth _____

PRESCRIPTION INFORMATION

New Prescription Refill RX# _____

Pet Name _____ Species _____

Drug _____ Strength _____

Qty _____ Form _____ Flavor or Base (if applicable) _____

Sig (Instructions)

Number of Refills _____

Controlled Substance: Yes No *If yes, Owner's Driver's License Information Required. Note: All orders that include controlled substances will need to be Billed and Shipped to Owner and will require a signature at delivery.

Is this for a food producing animal: Yes No

This drug will make a clinical difference for this patient. It is not available in this form, strength, flavor, D/C or B/O:

Yes No

CONFIDENTIALITY NOTICE

The attached document contains information that may be confidential and is intended only for use by the addressees. If you have received this facsimile in error, please notify us immediately by telephone at 833-633-4838.