Physician's Office Information

Practice/Prescriber's Name:_____

Address City, State Zip:_____

Phone:_____ Fax: _____

Fax To: Buderer Drug Co., Sandusky 419-626-0494

Date:_____/_____/_____ **Patient Name:**_____

Address City, State Zip:_____

Date of Birth: _____/_____/_____ **Patient Phone:**_____

Allergies:_____

Please choose one of the following protocol options:

☑ ***Rx:*** ***(CK3) Menadione Sodium Bisulfite 5mg/Sodium Ascorbate 500mg capsule***

Sig: Take 2 capsules five times a day with food. Keep refrigerated. ☐ **Other:**

Dispense: ☑ **# 300 caps** ☐ **Other Qty: #**_____ ***Refills:*** **1 2 3 4 5 Other:** Unlimited

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~~☐ ***Rx:*** ***(CK3) Menadione Sodium Bisulfite 5mg/Sodium Ascorbate 500mg capsule***~~

~~***Sig: Take 2 capsules twice a day with food. Keep refrigerated.***~~ ☐ **Other:**

~~***Dispense:*** ☐ **# 300** ☐ **Other Qty: #**_____ ***Refills:*** **1 2 3 4 5 Other:**_____~~

Physician Signature: _____

Print Name:_____ **Agent sending fax:**_____

BUDERER DRUG CO.
Est. 1878

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