Compounded Prescription Order Form

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Allergies: _____ **Phone**: (_____) _____

COMPOUNDED MEDICATION

Scream Cream

(L-Arginine 60mg + Pentoxifylline 50mg + Sildenafil 10mg + Testosterone 1mg + Theophylline 20mg) PER ML

Sig: Apply 1-2 pumps (0.5-1ml) to clitoris/vaginal area 30-60 minutes prior to need (max once daily)

Quantity: 30ml Refills _____

Prescriber Signature: _____ **Today Date:** _____

Prescriber Printed Name: _____ **□MD □DO □ND □PA □NP □CNM/CN**

State License: _____ **DEA:** _____ **NPI:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

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