

# Corvallis Drug Compounding Pharmacy

1090 Main Street/P.O. Box 9, Corvallis, MT 59828

Phone: (406)961-3221 Fax: (406)961-4344

## PATIENT INFORMATION

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
PATIENT DATE OF BIRTH

\_\_\_\_\_  
PATIENT ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
PATIENT PHONE NUMBER

\_\_\_\_\_  
DRUG ALLERGIES:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RX #1	RX #2
Date: _____	Date: _____
Drug: _____	Drug: _____
Sig: _____	Sig: _____
Qty: _____	Qty: _____
Refills: _____	Refills: _____
Special Instructions: _____	Special Instructions: _____
_____	_____
_____	_____

## PRESCRIBER INFORMATION

\_\_\_\_\_  
PRESCRIBER NAME

\_\_\_\_\_  
DEA NUMBER

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE