Please write prescriptions for **<Patient's name>** for the following checked items and remember to have generic dispensed.:

Return them in the SASE provided. If controlled substances are requested, do not date or mail on a Friday.

Thanks,

<Patient's name>

DATE: _____ # Scripts checked: _____

Controlled Substances

[ ] Oxycontin ER (Oxycodone) 10 mg, #20
	Take 3 tablets by mouth every 12 hours as needed for pain.

Normal Prescriptions

[   ] Glucophage [metformin HCL] 500 mg #360
	Take 2 tablets twice daily.
	Refills: 3

[   ] Lancets Multiclix 102's
	90 day supply
	Refills: 3

[   ] Optivar 0.05% Opth Soln (90 day supply)
	(Antihistimine/lubercant): <Dr's. Name>
	Instill 1 drop both eyes twice daily.
	Refills 3

Filename: Prescription Renewal Template.doc
Last revision: July 2009; added Levemir, deleted Diabeta

Make sure that there is an odd number of pages. (word formatting used)

<Doctor's name>
<Doctor's address>

<Pattient's name>
<Patient's address>

<Doctor's name>
<Doctor's Address>

<Patient's name>
<Patien't address>