PATIENTS NAME:	DATE:
ADDRESS:	D.O.B:

PAIN MEDICATION:

				REFILLS:
Dihydrocodeine/acetaminophen /caffeine "TREZIX"	30/320.5/16	SIG:Take 1 Tablet by mouth once daily	30 capsules	

MUSCLE RELAXANT MEDICATION:

				REFILLS:
ORPHENADRINE ER "NORFLEX"	100MG	SIG:Take 1 Tablet by mouth twice daily	60 tablets	

ANTI-INFLAMMATORY MEDICATION:

				REFILLS:
KETOPROFEN "ORDUS"	75MG	SIG:Take 1 capsule by mouth once daily	30 capsules	
NAPROXEN "ANAPROX DS"	550MG	SIG:Take 1 tablet by mouth twice daily	60 tablets	

ULCER MEDICATION:

				REFILLS:
FAMOTIDINE "PEPCID"	20MG	SIG:Take 1 tablet by mouth twice daily	60 tablets	

SLEEP MEDICATION:

				REFILLS:
ESZOPICLONE "LUNESTA"	3MG	SIG:Take 1 tablet by mouth at bedtime	30 tablets	

ADDITIONAL REQUESTED MEDICATIONS:

TRANSDERMAL
MUSCLE RELAXANT

MENTHODERM GEL 240GM

*SIG: APPLY A THIN LAYER TO AFFECTED AREA 2-3 TIMES A DAY OR AS DIRECTED BY PHYSICIAN

APPROVED BY: DATE:

FOR DOCTOR: Doctor's Signature

Based on the Patient's condition, symptoms and diagnosis and in compliance with title &, California code of regulations 4600(B) I hereby notify that the prescribed Medical prescription is medically necessary to relieve patient's symptoms caused by his/her condition.