IBS-80 Prescription Order Sheet

Patient: _____ Date: _____

Address: _____

Date of Birth: _____

Check one:

IBS-80 Basic Patch Test: _____

IBS-80 Plus Patch Test: _____

Known Food Allergies: _____

Specify month and date for delivery: Month _____

_____ 2nd Thursday/Friday of month, or _____ 4th Thursday/Friday of month

(Prescription must be received via fax at least 7 days prior to delivery date.)

Prescriber Information

Provider: _____

Address: _____

Phone: _____ Fax: _____

NPI: _____ State License: _____

Provider signature: _____

Billing Information

Name on Credit Card: _____

Billing Address: _____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Fax to The Compounding Pharmacist, West Chester, PA

Fax: 610-692-8505