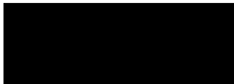
MARK DRUGS PHARMACY
Better Health and Care, Not Just Healthcare!
Roselle (630) 529-3400 • Deerfield (847) 419-9898

Mark Drugs Roselle, Phone 630-529-3400, Fax 630-529-3429

FOR OFFICE USE ONLY



1. Patient Information

Patient: ____
Address: __________________________________Apt. #_____
City _____________St: ____ Zip: ______

Home Phone: (____)____- ______Cell Phone:(____)____- ______
Work Phone: (____)____- ______

Sex: M ___ F ___ DOB: (mm/dd/yyyy)___/____/____
Age: ______
Medical Insurance (or fax ID card):_________________________
ID #:____________________Group#: ____________________

2. Diagnosis

- ☐ 473.9 CRS, Unspecified
- ☐ 477.9 Allergic Rhinitis, Unspecified
- ☐ 461.9 Acute Sinusitis, Unspecified
- ☐ 473.0 Chronic Sinusitis, Maxillary
- ☐ 473.1 CRS, Frontal
- ☐ 473.2 Chronic Sinusitis, Ethmoidal
- ☐ 473.3 CRS, Sphenoidal
- ☐ 461.8 Acute Sinusitis, Pansinusitis
- ☐ 473.8 CRS, Pansinusitis
- ☐ 117.9 Mycoses, Unspecified
- ☐ Other _________________

3. Medication Allergies

1. _______________ 2. ________________
3.________________ 4. ________________

Please attach sheets as needed for additional allergies

4. Culture / Sensitivity / Comments

Organism: _________________ Sensitivity: ____________
Comments: ____
____

5. Prescriptions

We offer the following compounded medications most often ordered by physicians. Please call to speak to our pharmacist if a needed medication is not listed here or **a combination of the items below is needed**.

☑ **NasoNeb Nasal Nebulizer ;** unit dose normal saline will be provided for 30 days per dose indicated

Medications (BID x 30 days unless otherwise indicated)	Refills	Dose	Sig	Days
Budesonide **0.5mg** or **0.6mg**/5ml Nasal Neb Susp x 100ml				
Mometasone Furoate 0.6mg/5ml Nasal Neb Susp x 100ml				
Itraconazole 40mg/5ml Nasal Neb Susp x 100ml				
Levofloxacin 100mg/5ml Nasal Neb Soln x 100ml				
Mupirocin 5mg/5ml Nasal Neb Susp PF x 100ml				
Tobramycin 165mg/5ml Nasal Neb Soln x 100ml				
Vancomycin HCL 160mg/5ml Nasal Neb Soln x 100ml				
Other:				

Please note: The NasoNeb Handheld Device and Tubing should be replaced every 6 months when patient is on maintenance therapy

6. Physician Signature

I have reviewed my patient's medical records and determined that the medications and supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal requirements by retaining a copy of this prescription in the patient's medical records. The prescriptions are to be dispensed as written unless otherwise instructed by me.

Signature: ____ Date: (mm/dd/yyyy)___/____/_____
Physician: ____ Specialty: ____________________
Address: ____City __________St: ____ Zip: ______
State License #:______________________________ NPI #:__________________________________
Office Contact: ____________________________Phone: (____)____- ______ Fax: (____)____- ______

Fax completed form to Mark Drugs: 630-529-3429

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Additional Doctor Notes & Instructions

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