Attention: Medication Department

Rexall Drug **WL INFUSION Services**

PATIENT INFORMATION

Patient Name:			**Date of Birth:**
Social Security #:	**HT:**	**WT:**	**Sex: M** _____ **F** _____
Address:			
City:	**State:**		**Zip Code:**
Home Phone:	**Alternate Phone:**		
Any Allergies:			
Primary Insurance:	**Phone:**		
ID#:	**Group #:**		
Employer:	**Subscriber's Name:**		

PATIENT DIAGNOSIS

Wound Information:

Wound #1: □ ____ cm x ____ cm Location: _____

Wound #2: □ ____ cm x ____ cm Location: _____

Wound #3: □ ____ cm x ____ cm Location: _____

Wound #4: □ ____ cm x ____ cm Location: _____

Wound #5: □ ___ cm x ____ cm Location: _____

Wound #6: □ ___ cm x ____ cm Location: _____

Wound #7: □ ___ cm x ____ cm Location: _____

Other: □ _____

PRESCRIPTION

Orders:

□ **Collagenase SANTYL Ointment (250 units/g)** □ **30g** □**90g**

□ **Regranex 0.01% Gel 15 gm**

Sig: Apply to wound once daily (or more frequently if the dressing becomes soiled) for _____30_____ days

Quantity: □ Dispense qty sufficient for **30 days** **Refills**: _____3_____

PHYSICIANS INFORMATION

Physician's Name: ERIC TRAVIS, DPM	**Phone:** 949.855.4414	**Fax:** 949.598.9443	
Physician's address: 24310 MOULTON PARKWAY SUITE A	**City:** LAGUNA WOODS	**State:** CA	**Zip Code:** 92637
Physician's NPI: 1104926070			
Signature:		**Date:**	

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