



7017 S. Staples St Ste 103B Corpus Christi, Texas 78413

P:361-356-6279

F:361-480-0090

Patient: _____

Address: _____

Phone: _____ DOB: _____

Refills **0 1 2 3 4** Date: _____

SEMAGLUTIUDE SUBLINGUAL		
<input type="checkbox"/> 0.3mg Twice Weekly for 4 weeks QTY _____	<input type="checkbox"/> 0.6mg Twice Weekly for 4 weeks QTY _____	<input type="checkbox"/> 1.2mg Twice Weekly for 4 weeks QTY _____
<input type="checkbox"/> 2.4mg Twice Weekly for 4 weeks QTY _____	<input type="checkbox"/> 3.6mg Twice Weekly for 4 weeks QTY _____	<input type="checkbox"/> QTY _____
<input type="checkbox"/> Alli Diet Weight Loss Supplement 60 mg Capsule -1 Capsule with meals QTY _____	<input type="checkbox"/> Purely Optimal Keto BHB Exogenous Supplement -2 Capsules Daily QTY _____	<input type="checkbox"/> Physician's Choice Probiotic 60 Billion CFU + Organic Prebiotic -1 Capsule Daily QTY _____
Dispense Quantity and Sig:		

Prescriber _____

Address: _____

Phone: _____ Fax: _____

Prescriber Signature: _____

NPI: _____