



Memorial Pharmacy and Compounding

7017 S. Staples St Suite 103B

Corpus Christi, Texas 78413

Phone: 361-356-6279 Fax: 361-480-0090

Date: _____ Date of Birth: _____ Patient: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Owner: _____

All compounds for clinical use will require a written prescription for each individual patient. Medication will be dispensed in patient specific package.

Commonly Requested Veterinary Formulations

<input type="checkbox"/> Amitriptyline ___ mg Qty: _____ <input type="checkbox"/> Cream ___ mg/0.1mL <input type="checkbox"/> Beef or Chicken ___ mg/mL	<input type="checkbox"/> Methimazole ___ mg Qty: _____ <input type="checkbox"/> Cream ___ mg/0.1mL <input type="checkbox"/> Beef or Chicken ___ mg/mL
<input type="checkbox"/> Pimobendan ___ mg Qty: _____ <input type="checkbox"/> Capsule <input type="checkbox"/> Beef or Chicken ___ mg/mL	<input type="checkbox"/> Metronidazole ___ mg Qty: _____ <input type="checkbox"/> Capsule <input type="checkbox"/> Beef or Chicken ___ mg/mL
<input type="checkbox"/> Diazepam ___ mg Qty: _____ <input type="checkbox"/> Suppository <input type="checkbox"/> Beef or Chicken ___ mg/mL	<input type="checkbox"/> Potassium Bromide ___ mg Qty: _____ <input type="checkbox"/> Capsule <input type="checkbox"/> Beef or Chicken ___ mg/mL
<input type="checkbox"/> Doxycycline ___ mg Qty: _____ <input type="checkbox"/> Beef or Chicken ___ mg/mL	<input type="checkbox"/> Trilostane ___ mg Qty: _____ <input type="checkbox"/> Capsule <input type="checkbox"/> Beef or Chicken ___ mg/mL
<input type="checkbox"/> Fluoxetine ___ mg Qty: _____ <input type="checkbox"/> Cream ___ mg/0.1mL <input type="checkbox"/> Beef or Chicken ___ mg/mL	<input type="checkbox"/> Prednisolone ___ mg Qty: _____ <input type="checkbox"/> Cream ___ mg/0.1mL <input type="checkbox"/> Beef or Chicken ___ mg/mL
<input type="checkbox"/> Gabapentin ___ mg Qty: _____ <input type="checkbox"/> Cream ___ mg/0.1mL <input type="checkbox"/> Beef or Chicken Liquid ___ mg/mL	Sig: _____ Refills: _____

Prescriber: _____

Prescriber Phone: _____ NPI: _____

Prescriber Signature: _____

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Otic Gel (Ciprofloxacin 2% Ketoconazole 2% Triamcinolone 0.25%)

*Medication should be administered by veterinarian during office visit.
* Recommended repeat application 1 week after 1st dose.

3ml (1.5ml each visit) one ear 6ml (1.5ml each visit) both ears
 8ml (4ml each visit) one ear 16ml (4ml each visit) both ears

*For dogs less than 90 lbs. instill 1.5ml into each affected ear
*For dogs greater than 90 lbs. instill 4ml into each affected ear

Otic Powder (Boric Acid 25% Clotrimazole 1%)

10 gm in accordion puffer Other ____ gm
Sig: Puff 2 puffs into affected ear twice daily

Tritop (Neomycin 0.5%, Triamcinolone 0.1%, Tetracaine 0.5%)

Qty: _____
Sig: _____

Cisapride ____ mg Qty: _____
 Cream ____ mg/0.1mL Beef Flavored Liquid ____ mg/mL

Phenylpropanolamine ____ mg Qty: _____
 Capsule

Other: _____
Sig: _____
Refills: _____

Prescriber: _____

Prescriber Phone: _____ NPI: _____

Prescriber Signature: _____

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