Compound Care Plus Pharmacy

Please Print out, Complete,
and Fax to:
866-832-2264

Phonophoresis Compound Order Form

Date: ________________________ Physician Name: ________________________

Facility Name: ________________________ Physician DEA: ____________________

Shipping Address: ____

Billing Address: ____

City: ________________________ State: __________ Zip: ____________________

Telephone: ____________________ Fax: ______________________________

Physician Signature:____________________________ **Refills:** ______________

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Patient Name: ______________________________Date of Birth: ____________________

Address: ________________________ City: __________ ST: _____ Zip: __________

Telephone: (   ) ____________________ Allergies: ______________________________

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Product	*Strength*	*Package Size*	*Quantity*
Hydrocortisone UltraSound Gel	1.0 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Hydrocortisone UltraSound Gel	10 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Ketoprofen Ultrasound Gel	10 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Dexamethasone Ultrasound Gel	0.4 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Dexamethason/Lidocaine US Gel	0.4% /4.0%	2 oz 4 oz 8 oz 12 oz 16 oz	
Fluocinonide Ultrasound Gel	0.05 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Other:			

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