MAXOR C-2 Prescription Form

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date

INSTRUCTIONS:

1) ONLY ONE PRESCRIPTION TO BE ORDERED ON EACH FORM
2) COMPLETE ALL REQUIRED INFORMATION
3) THIS FORM TO BE USED FOR PATIENT SPECIFIC ORDERS ONLY
4) PRESCRIBER MUST SIGN AND DATE ON DAY OF ISSUANCE
5) MAIL THE COMPLETED RX FORM TO:
   MAXOR CORRECTIONAL PHARMACY SERVICES
   ATT: CONTROLS PHARMACIST
   416 MARY LINDSAY POLK DRIVE, SUITE 515
   FRANKLIN, TENNESSEE 37067

Patient Name		ID#	DOB	Date
Facility	Facility #	Facility Address		
Facility Telephone Number		Facility Telephone Fax		

(DO NOT WRITE IN THIS SPACE)

Rx _____ **C. II** (ONLY

DRUG _____ **STRENGTH** _____

DOSAGE FORM _____ **QUANTITY TO DISPENSE** _____

DIRECTIONS FOR USE: _____

_____

_____

DO NOT SUBSTITUTE IF BOX CHECKED: [ ]

Provider Name	DEA #
Provider Signature	Date

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