

Patient Name _____ D.O.B _____ Date _____

Address _____ Phone # _____

Allergies _____

Wound Care Applications (To be compounded – Commercially available products not sufficient for treatment.)

Fixed Dose Combinations		
<input type="checkbox"/> Debridement Powder Urea 15% Sucralfate 5% Acetylcysteine 5% EDTA 0.5% GHK-Cu 0.05% PLUS <input type="checkbox"/> Metronidazole 2% <input type="checkbox"/> Lidocaine 2% Qty: Q.S. for wound size Day Supply: 30 days Sig: Clean site and apply to affected area with each dressing change	<input type="checkbox"/> Skin Conditioning/Repair Cream Emu Oil 6% CoQ10 0.5% Urea 10% Salicylic Acid 1.5% Aloe Vera 1% Qty: 80 grams Day Supply: 30 days Sig: Apply 0.5 - 1 gram to affected area 2-3 times daily.	<input type="checkbox"/> Keratolytic Cream Urea 20% Salicylic Acid 7% Aloe Vera (200:1) 1% Qty: Q.S. for wound size Day Supply: 30 days Sig: Apply 0.25 gram to affected area twice daily.
<input type="checkbox"/> Wound Care Gel - Closure Sildenafil 6% Allantoin 1% Pentoxifylline 2% GHK-Cu 0.05% Qty: Q.S. for wound size Day Supply: 30 days Sig: Apply 0.5 - 1 gram to affected area daily or as directed.		<input type="checkbox"/> Closure Powder Allantoin 0.5% Sildenafil 6% Pentoxifylline 2% Naltrexone 0.03% GHK-Cu 0.05% Sucralfate 5% PLUS <input type="checkbox"/> Gentamicin 0.2% Qty: Q.S. for wound size Day Supply: 30 days Sig: Clean/dry site prior to application. Aspirate thin layer of powder onto surface of wound with each dressing change.
<input type="checkbox"/> Pain Ointment *Note: Application to intact skin ONLY Benzocaine 20% Lidocaine 10% Tetracaine 6% Qty: 30 grams Day Supply: 30 days Sig: Apply 1 gram to affected area as directed.	<input type="checkbox"/> Wound Care Gel – Fissure Diltiazem 2% Lidocaine 2% GHK-Cu 0.05% PLUS <input type="checkbox"/> Hydrocortisone 2% Qty: 30 grams Day Supply: 30 days Sig: Apply 0.25 gram to affected area 3-4 times daily.	<input type="checkbox"/> Arthritis / Neuropathy / Sciatica - Cream Ketoprofen 15% Gabapentin 6% Clonidine 0.2% Lidocaine 5% PLUS <input type="checkbox"/> Pentoxifylline 5% Qty: 120gm Day Supply: 30 days Apply 0.5 to 1 gram to affected area(s) 3 to 4 times daily.
Custom Combinations		
Step 1 (Anti-Infective Selection) <input type="checkbox"/> Amphotericin 0.3% <input type="checkbox"/> Colistimethate 0.3% <input type="checkbox"/> Itraconazole 1% <input type="checkbox"/> Mupirocin 2% <input type="checkbox"/> Tobramycin 0.8% <input type="checkbox"/> Amp-Sul 4.5% <input type="checkbox"/> Daptomycin 1.5% <input type="checkbox"/> Levofloxacin 2% <input type="checkbox"/> Nystatin 100,000 U/gm <input type="checkbox"/> Ceftazidime 3% <input type="checkbox"/> Doxycycline 2% <input type="checkbox"/> Meropenem 3% <input type="checkbox"/> Pip-Tazo 13.5% <input type="checkbox"/> Clindamycin 2% <input type="checkbox"/> Gentamicin 0.6% <input type="checkbox"/> Metronidazole 2% <input type="checkbox"/> TMP-SMX 1%-5% <input type="checkbox"/> Vancomycin 3% <input type="checkbox"/> Other _____		
Step 2 (Perfusion/Cell Growth/Pain/Misc) <input type="checkbox"/> Allantoin 0.5% <input type="checkbox"/> Lidocaine 2% <input type="checkbox"/> Pentoxifylline 2% <input type="checkbox"/> Sucralfate 5% <input type="checkbox"/> GHK-Cu 0.03% <input type="checkbox"/> Naltrexone 0.03% <input type="checkbox"/> Prilocaine HCl 2% <input type="checkbox"/> Iodoform 2% <input type="checkbox"/> Nifedipine 0.2% <input type="checkbox"/> Sildenafil 6% <input type="checkbox"/> Zinc Oxide 25%		
<input type="checkbox"/> Plasma Therapy: 15mls prefilled syringes Sig: Use as directed with dressing changes		
<input type="checkbox"/> Mucoadhesive Powder (g) Sig: Clean/dry site prior to application. Aspirate thin layer of powder onto surface of wound with each dressing change. <input type="checkbox"/> Wound care gel (g) Sig: Clean/dry site prior to application. Apply gel directly into wound bed with each dressing change.		
Qty: <input type="checkbox"/> 15g(ml) <input type="checkbox"/> 30g(ml) <input type="checkbox"/> 60g(ml) <input type="checkbox"/> 120g(ml)		

Refills: 1 2 3 4 5 prn zero

Wound Measurements (cm): _____

Frequency of Dressing Changes: _____

*Prescriber (Name/Signature) _____

*Phone # _____ *NPI/DEA # _____

MMC Pharmacy

117 Fountains Blvd Madison MS

Phone: (601) 707-7545

Fax: (601) 856-8985