uresta®

Patient Name:	
Patient Date of Birth:	
Patient Cell Phone:	
Patient Shipping Address:	
Patient Allergies:	
Prescription Info	**Drug Name:** **Quantity:** **Refills:** **Directions:** **Substitution not allowed:** **Comment:**
Prescriber Name:	
Prescriber NPI:	
Prescriber Signature & Date:	
Prescriber Phone:	
Prescriber Fax:	
Prescriber Address:	

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