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**www.mypsychedelicpharmacy.com**
**Tel: 224-244-7188**
**mypsychedelicpharmacy@gmail.com**

# ORDER FORM - PRESCRIPTION

**Practice Name**

**Email**

**Name**

First Name Last Name

**DEA#**

**License#**

**Address**

Street Address

City

State

Zip Code

**Prescriber Name**

**Prescriber Email**

example@example.com

## Patient Information

**Name**

First Name Last Name

**Email**

example@example.com

**Patient DOB**

Month Day Year

**Address**

Street Address

City

State

Zip Code

**Diagnosis**

**Allergies**

**Last Office Visit Date**

Month Day Year

**Copy of Patient's Drivers License Attached**

- YES
- NO

- Charge to Clinic
- Ship to Patient
- Ship 2nd Day
- Charge to Patient

## Oxytocin Capsules - 10/pc bottle

**Strength**

- 40mg
- 60mg
- 100mg
- 200mg
- 300mg

**Quantity**

**Refills**

**Doctor Signature**

## Oxytocin Cream

**Strength**

- 30mg

**Quantity**

**Refills**

**Doctor Signature**

**Diagnosis**

## Ketamine Troches - 10pc/bottle

**Strength**

- ○ 50mg
- ○ 100mg
- ○ 150mg
- ○ 175mg
- ○ 200mg
- ○ 225mg
- ○ 250mg
- ○ 300mg
- ○ 350mg
- ○ 400mg

**Quantity**

**Refills**

**Doctor Signature**

## Ketamine Cream

**Tube Size**

- ○ 30gm
- ○ 60gm

**Quantity**

**Refills**

**Doctor Signature**

## Ketamine Suppositories  30pc/bottle

**Strength**

- ○ 100mg
- ○ 200mg
- ○ 300mg
- ○ 400mg

**Quantity**

**Refills**

**Doctor Signature**

**Patient received counseling on the need to monitor for sedation and disassociation**

- ○ YES
- ○ NO

**Medication Instructions**

**Submitted By**

**Title**

**Signature**

**Date**

Month Day Year

**180 N. Michigan Ave. Chicago, IL, 60601 - 224-244-7188 mypsychedelicpharmacy@gmail.com**