

**Pediatric** Compounded Medication Order Form

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| PATIENT       |                 |                  |  |
|---------------|-----------------|------------------|--|
| First name    |                 | Last name        |  |
| Date of birth |                 |                  |  |
| Address       |                 | City, State, ZIP |  |
| Primary phone | Secondary phone | Allergies        |  |

| NAUSEA FORMULATIONS                                                                                                                                                                                                                     |                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Promethazine Transdermal Cream (circle strength) 25mg/0.2ml or 6.25mg/0.1ml</b><br><b>Sig:</b> Apply _____ topically to inner wrist every _____ hours as needed.<br><b>Qty:</b> _____ <b>Refills:</b> _____ | <input type="checkbox"/> <b>Ondansetron Transdermal Cream 4mg/0.1ml</b><br><b>Sig:</b> Apply _____ topically to inner wrist every _____ hours as needed.<br><b>Qty:</b> _____ <b>Refills:</b> _____ |

| DIAPER RASH FORMULATIONS                                                                                                                                                                                                              |                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Cholestyramine in Aquaphor Ointment 10%</b><br><b>Sig:</b> AAA with each diaper change<br><b>Qty:</b> <input type="checkbox"/> 60gm Other: _____<br><b>Refills:</b> _____                                 | <input type="checkbox"/> <b>Cholestyramine 10%/Nystatin 50,000 units/gm Ointment</b><br><b>Sig:</b> AAA with each diaper change<br><b>Qty:</b> <input type="checkbox"/> 60gm Other: _____<br><b>Refills:</b> _____                |
| <input type="checkbox"/> <b>Cholestyramine 10%/Mupirocin 1% Ointment</b><br><b>Sig:</b> AAA with each diaper change<br><b>Qty:</b> <input type="checkbox"/> 60gm Other: _____<br><b>Refills:</b> _____                                | <input type="checkbox"/> <b>Cholestyramine 10%/Mupirocin 0.5%/Nystatin 25,000 units/gm Ointment</b><br><b>Sig:</b> AAA with each diaper change<br><b>Qty:</b> <input type="checkbox"/> 60gm Other: _____<br><b>Refills:</b> _____ |
| <input type="checkbox"/> <b>Magic Butt - Nystatin (Nystatin 33%, Antacid 33%, Zinc Oxide 33%) Paste</b><br><b>Sig:</b> AAA with each diaper change<br><b>Qty:</b> <input type="checkbox"/> 60gm Other: _____<br><b>Refills:</b> _____ | <input type="checkbox"/> <b>K-Med Ointment</b><br><b>Sig:</b> AAA with each diaper change<br><b>Qty:</b> <input type="checkbox"/> 60gm Other: _____<br><b>Refills:</b> _____                                                      |
| <input type="checkbox"/> <b>K-Med/Hydrocortisone 1% Ointment</b><br><b>Sig:</b> AAA with each diaper change<br><b>Qty:</b> <input type="checkbox"/> 60gm Other: _____ <b>Refills:</b> _____                                           |                                                                                                                                                                                                                                   |

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Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

**ORAL FORMULATIONS**☐ **Omeprazole Oral Suspension (circle strength) 2mg/ml or 5mg/ml**

Sig: \_\_\_\_\_

Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

☐ **Lansoprazole Oral Suspension (circle strength) 3mg/ml or 5mg/ml**

Sig: \_\_\_\_\_

Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

☐ **Metronidazole Benzoate Oral Suspension**

Sig: \_\_\_\_\_

Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

**OTIC FORMULATIONS**☐ **Antipyrine 5.4%/Benzocaine 1.4% Otic Drops**

Sig: \_\_\_\_\_

Qty: ☐ 15ml Other: \_\_\_\_\_ Refills: \_\_\_\_\_**WART TREATMENTS**☐ **Potassium Hydroxide Solution 10%**

Sig: AAA with flat-ended toothpick until irritation occurs.

Qty: ☐ 15ml Other: \_\_\_\_\_

Refills: \_\_\_\_\_

☐ **Wart Magic (Salicylic Acid 20%/Lactic Acid 10%/Formaldehyde 8% in Flexible Collodion)**

Sig: AAA after debridement, cover overnight and wash off in am

Qty: ☐ 15ml Other: \_\_\_\_\_

Refills: \_\_\_\_\_

☐ **Salicylic Acid 20%/5-Fluorouracil 5% Topical Solution**

Sig: AAA after debridement, cover overnight and wash off in am

Qty: ☐ 15ml Other: \_\_\_\_\_ Refills: \_\_\_\_\_

Additional formulas are available. Please contact the pharmacist at 419-784-4800 with any questions.

**PRESCRIBER**

Prescriber name (print)

NPI #

DEA #

Address

City, State, ZIP

Phone

Prescriber signature

Date