pdlabs
prescription dispensing laboratories

Plantar Fibromatosis New Patient Form

Please fax to: (toll-free) 866-687-2217

Physician Information

Organization ______________________________ *Date* ______________

Name ______________________________ *DEA #* ______________ *NPI#* ______________

Address ______________________________ *City* ______________ *State* ________ *Zip* ________

Phone # ______________ *Fax #* ______________ *Email* ______________

Patient Information

Male *Female*

Name ______________________________ *Email* ______________ *DOB* ________

Address ______________________________ *City* ______________ *State* ________ *Zip* ________

Phone # ______________________________ *HIPPA Contact(s)* ______________

Medications ______________________________

Allergies ______________________________

Family History? Yes / No *Prior Surgery Yes / No* *Time w/condition* ______________

Left Foot

Pain (1-10) ________ *Nodule(s)* ________

Size ______________

Right Foot

Pain (1-10) ________ *Nodule(s)* ________

Size ______________

❑ *Patient has been offered counseling by a PDLabs' pharmacist regarding this prescription.*

Transdermal Verapamil 15% Gel in PDLabs' Vehicle # 062003BE for Plantar Fibromatosis

(Compounded using proprietary formulation and mixing specifications licensed exclusively to PDLabs)

Sig: Apply two 0.5mL (1.0mL) bid to each affected foot using dosimeters provided by PDLabs as directed.

#90 Days Left Foot ❑ Right Foot ❑ Both ❑ Refills: ________

Physician's Signature ______________________________ *Date* ______________

Dispense As Written

***Note:** This product is protected under U.S. Utility Patent Numbers 6,031,005 and 6,353,028.*