



# Rejuvi Pharmaceuticals

**FAX: 561-362-3361**

## **Prescription Order Form**

**Patient:**

\_\_\_\_\_  
Name Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone (H) (W)

\_\_\_\_\_  
Date of Birth Allergies

**Prescription:**

\_\_\_\_\_  
Drug Strength Dosage Form Quantity

\_\_\_\_\_  
Directions (Dose, Route of Administration, Frequency) Refills

**Doctor Information:**

\_\_\_\_\_  
Doctor Name (Please Print) Signature

\_\_\_\_\_  
DEA# License # Phone Number Fax Number

\_\_\_\_\_  
Doctor Address (if first time ordering) City State Zip

**Shipping Information:** (please check all that apply)

\_\_\_\_ Ship to Doctor \_\_\_\_ Ship to Patient \_\_\_\_ Bill credit card on file

\_\_\_\_ Bill the following credit card \_\_\_\_ Ship DHL Overnight  
(Recommended)

Name on Card: \_\_\_\_\_ \_\_\_\_ Ship DHL 2<sup>nd</sup> Day

# \_\_\_\_\_ \_\_\_\_ Ship DHL Ground

Exp. date \_\_\_\_\_ 3 Digit Code (on back) \_\_\_\_\_