The Medicine Shoppe® Shillington, PA

Send To: 101W Lancaster Ave Shillington PA 19607

Phone *: (610) 777-2313* **Fax *to: (610) 777-2319***

PATIENT NAME: _____ **DOB:** _____ **Phone**_____

ADDRESS: _____ **Allergies**_____

Please complete the above demographics or send in a face sheet.

Semaglutide

☐ **Semaglutide 2.5mg/mL Injection Solution MDV (QTY #2mL)**
SIG: Inject 10 units (0.25mg) subcutaneously once a week for 4 weeks.

☐ **Semaglutide 2.5mg/mL Injection Solution MDV (QTY #2mL)**
SIG: Inject 20 units (0.5mg) subcutaneously once a week for 4 weeks.

☐ **Semaglutide 2.5mg/mL Injection Solution MDV (QTY #2mL)**
SIG: Inject 40 units (1mg) subcutaneously once a week for 4 weeks.

☐ **Semaglutide 2.5mg/mL Injection Solution MDV (QTY #4mL)**
SIG: Inject 68 units (1.7mg) subcutaneously once a week for 4 weeks.

☐ **Semaglutide 2.5mg/mL Injection Solution MDV (QTY #4mL)**
SIG: Inject 96 units (2.4mg) subcutaneously once a week for 4 weeks.

CUSTOM SEMAGLUTIDE

☐ **Semaglutide 2.5mg/mL Injection Solution MDV (QTY ☐ #2mL ☐ #4mL)**
SIG: Inject _____mg subcutaneously_____time(s) a week for_____weeks.

NAUSEA

☐ **Ondansetron 4mg ODT Tablets (QTY ☐ #10 ☐ #30)**
SIG: Place 1 tablet on the tongue, allow to dissolve then swallow every 8 hours as needed for nausea.

PRESCRIBER NAME: _____ **NPI:** _____ **DEA:** _____

ADDRESS:

PHONE: _____ **FAX:** _____ **CONTACT PERSON:** _____ **REFILLS:** _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____ _____