FAX TRANSMITTAL TO WATKINS PHARMACY **231-737-1329**
EMAIL: WATKINSPHARMACY@WATKINSPHARMACY.COM

WATKINS
PHARMACY
1391 E SHERMAN BLVD
MUSKEGON, MI 49444
(231) 739-7158

PCAB ACCREDITED Compounding Pharmacy

PET NAME: _____ **DATE:** _____
OWNER NAME: _____ **WEIGHT:** ____#_____
ADDRESS: _____ **CITY:** _____ **ZIP:** _____
PHONE: __(____)_____ **SPECIES:** _____ **ALLERGIES:** _____

All compounds will require a written prescription for each individual patient.

COMMON VET FORMULAS (SHEET 2 OF 5)

DOXYCYCLINE *SUSPENSION*

____ 25mg/ml ____ 50mg/ml ____ 100mg/ml

QTY: _____ Refills: _____

SIG: _____

DOXYCYCLINE *CAPSULES*

___ 200mg ___ 250mg ___ 400mg

QTY: _____ Refills: _____

SIG: _____

ENROFLOXACIN *SUSPENSION*

___ 20mg/ml ___ 50mg/ml

QTY: _____ Refills: _____

SIG: _____

ENROFLOXACIN *CAPSULES*

___11.35mg ___ 204mg ___ 325mg

QTY: _____ Refills: _____

SIG: _____

METRONIDAZOLE *SUSPENSION*

___ 50mg/ml ___ 100mg/ml

QTY: _____ Refills: _____

SIG: _____

METRONIDAZOLE *MINI TABS*

___ 25MG ___ 50mg

QTY: _____ Refills: _____

SIG: _____

AMOXICILLIN/CLAV SUSPENSION

85mg/ml

QTY: _____ Refills: _____

SIG: _____

PRAZOSIN SUSPENSION

_____1mg/mg

_____

_____ mg CAPSULES

QTY: _____ Refills: _____

SIG: _____

CUSTOM FORMULAS WELCOME **LAB DIRECT: 231-683-1708** **FAX 231-737-1329**

Physician Name (Print): _____
Physician Signature: _____
DEA # _____ **Office Phone #:** _____