FOR FAX TRANSMITTAL 231-737-1329
EMAIL: WATKINSPHARMACY@WATKINSPHARMACY.COM

WATKINS PHARMACY

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

PCAB ACCREDITED Compounding Pharmacy

NAME: _____ **DATE:** _____

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

PHONE: __(____)_____ **ALLERGIES:** _____

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

BMX MOUTHWASH
(ratio: 1:1:1)

Sig: USE ONE TEASPOONFUL (5ml)
___ SWISH & SPIT
___ SWISH & SWALLOW

_____ TIME(S) PER DAY

Qty: _____ Refills: ____

BMNX MOUTHWASH
(ratio 1:1:1:1)

Sig: USE ONE TEASPOONFUL (5ml)
___ SWISH & SPIT
___ SWISH & SWALLOW

_____ TIME(S) PER DAY

Qty: _____` Refills: ____

BDNX MOUTHWASH
(ratio 1:1:1:1)

Sig: USE ONE TEASPOONFUL (5ml)
___ SWISH & SPIT
___ SWISH & SWALLOW

_____ TIME(S) PER DAY

Qty: _____ Refills: _____

BUILD YOUR OWN FROM LIST BELOW

RATIO ___ ___ ___ ___

Sig: USE ONE TEASPOONFUL (5ml)
___ SWISH & SPIT
___ SWISH & SWALLOW

_____ TIME(S) PER DAY

Qty: _____ Refills: _____

B=BENADRYL D=DEXAMETHASONE H=HYDROCORTISONE M=MYLANTA N=NYSTATIN
P=PREDNISOLONE T=TETRACYCLINE X=XYLOCAINE (LIDOCAINE) W=WATER

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

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