

Practitioner Name: _____

Patient Name: _____ Ship to: You (3 item min) Patient

Fill Out for Patient's 1st order only:

Phone: _____

Address: _____ City _____ State: _____ Zip: _____

Label: _____

Dosage: _____ droppers, _____ times/day

Size: 2oz 4oz

Prescription List in Pinyin or English

_____ Whole bottle 2/3 1/2 1/3 *Concen:* Std SC

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