iBS-80
THE IBS SKIN PATCH TEST

Prescription Order Sheet

Patient's Full Name: _____
Date: ___/___/___
Address: _____
Date of Birth: ___/___/___

Rx: IBS-80 Patch Test

Known Food Allergies: _____

***Specify date of patient appointment for patch test application: ___/___/___**

****Prescription must be received via fax at least 10 days prior to patient appointment date.**

<u>Prescriber Information</u>
Provider: _____
Address: _____
Phone: _____ Fax: _____
NPI: _____ State License: _____

Provider signature: _____

<u>Billing Information</u>
Name on Credit Card: _____
Billing Address: _____
Credit Card Number: _____
Expiration Date: _____ Security Code: _____

Fax to: 610-692-8505

The Compounding Pharmacist
720 E Market St Suite 155
West Chester, PA 19382
Phone: 866-692-8770 (call in prescription, if preferable)