

To: **Dynasty Pharmacy**
5460 Yonge St Unit 106
North York, ON-M2N 6K7
Phone: 416-250-5460
Fax: 416-250-5461

Patient Name _____
Address: _____
Date of Birth: _____
PHIN: _____
Phone: _____
Today's Date: _____

Or: _____

Popular combinations:

- Magic mouthwash – diphenhydramine 0.075%, hydrocortisone 0.125%, nystatin 7500u/ml, lidocaine 0.4%
- Super Magic Mouthwash – diphenhydramine 0.125%, dexamethasone 0.00033%, tetracycline 1.25%, lidocaine 1%
- Tetracaine 0.5%, hydrocortisone 1%, clotrimazole 2%, sucralfate 15.6%
- Ketamine 0.03%, tetracaine 0.5%, sucralfate 15.6% (requires a duplicate Rx)
- Pink Lady - Xylocaine Viscous 2% : Maalox, 1:1
- Modified Pink Lady – Xylocaine Viscous 2% : Maalox: Benadryl Elixir, 1:1:1

OR

Check the Ingredient & Strength:

Other Strength:

<input type="checkbox"/>	Ketamine	__0.03%	__0.4%	(requires a duplicate Rx)	_____%
<input type="checkbox"/>	Morphine	__0.2%	__0.5%	(requires a duplicate Rx)	_____%
<input type="checkbox"/>	Gabapentin	__6%			_____%
<input type="checkbox"/>	Lidocaine	__0.4%	__1%	__2%	_____%
<input type="checkbox"/>	Tetracaine	__0.5%	__1%		_____%
<input type="checkbox"/>	Diphenhydramine	__0.075%	__0.125%	__0.2%	_____%
<input type="checkbox"/>	Hydrocortisone	__0.125%%	__0.5%	__1%	_____%
<input type="checkbox"/>	Dexamethasone	__0.00033%			_____%
<input type="checkbox"/>	Sucralfate	__4%	__8%	__15.6%	_____%
<input type="checkbox"/>	Clotrimazole	__2%			_____%
<input type="checkbox"/>	Nystatin	__7500u/mL			_____u/mL
<input type="checkbox"/>	Tetracycline	__1.25%			_____%
<input type="checkbox"/>	Misoprostol	__0.0024%			_____%
<input type="checkbox"/>	Additional Ingredients:	_____	_____%		_____%

Directions: Swish and spit 10-15mL or _____mL q 2-3 hours or _____(frequency) as needed.

OR

Swish and swallow ____ ml _____ (frequency) as needed.
(consider systemic effects when determining volume and frequency if swallowing)

Mucolox Base:

Swish and spit 5ml BID to QID as needed.
Swish and swallow 5 – 10ml BID to QID as needed.

Mitte: _____mL **Refill x** _____

Physician Name (Print): _____
Address: _____
Phone: _____
Signature: _____

Prescription Certification: This prescription represents the original of the prescription. The pharmacy addressee noted above is the only intended recipient and there are no other. The original prescription has been invalidated and securely filed and it will not be transmitted elsewhere at another time.

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