

Anal Fissures / Hemorrhoids

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: _____

Topical Treatment

Check the Ingredient(s) & Strength

Nifedipine _____ 0.2% _____ 0.3% _____ 0.5%
Diltiazem _____ 2%

ONLY USE 1 OF THESE 3

Lidocaine _____ 1% _____ 2%
Hydrocortisone _____ 1% _____ 2%
Sucralfate _____ 2% _____ 4% _____ 7%
Misoprostol _____ 0.0024%

Other: _____ %

All products will be in Vaseline-type base

Mitte: _____ gm

Sig: Apply to the affected area 2 to 3 times daily and after a bowel movement

OR: _____

Refill: _____

Rectal Rocket Suppository

Check the Ingredients and Strength

Misoprostol _____ 0.0024%
Sucralfate _____ 15.6%
Hydrocortisone _____ 1% _____ 2%
Lidocaine _____ 1% _____ 2%
Nifedipine _____ 0.2% _____ 0.3% _____ 0.5%

Other: _____ %

Treatment for anal fissures is once daily at bedtime for 4 - 7 days.

(NOTE: Use of rectal rockets for hemorrhoids is often a 3 day treatment)

Mitte: _____ Rectal Rockets

Sig: Instil 1 rectal rocket at bedtime for _____ days. Lay in a supine position.

Refill: _____

**NOTE: USUALLY ALL 5
INGREDIENTS ARE USED
TOGETHER**

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 & there are no other. The original prescription has been invalidated & securely filed and it will not be transmitted elsewhere at another time.

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