State of New Jersey

PRESCRIPTION BLANK

DOCTOR
SPECIALTY
STREET
CITY STATE ZIP
PHONE

NPI # _____

CERTIFICATION # _____ DEA # _____

COLLABORATING PHYSICIAN

NAME _____ LICENSE # _____

(Enter Address and Phone Number only if different from above)

ADDRESS _____

_____ PHONE # _____

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

Rx

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____

REFILL _____ TIMES

SIGNATURE OF PRESCRIBER

Use a separate form for each controlled substance prescription

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