State of New Jersey

PRESCRIPTION BLANK

NAME, DEGREE, TITLE

STREET • CITY STATE ZIP

PHONE

LICENSE # _____ DEA # _____

AFFILIATED PHYSICIAN

NAME PHYSICIAN NAME LICENSE # 0000000

TELEPHONE # (000) 000-0000

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