

To: Tache Pharmacy
400 Tache Avenue
Winnipeg, Manitoba
Phone: (204) 233-3469
Fax: (204) 231-1739

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

Or: _____ Phone: _____

Urticaria/Pruritus:

<input type="checkbox"/> Doxepine 5%, Lidocaine <input type="checkbox"/> 2% <input type="checkbox"/> 5% in Xematop	
Add: Hydrocortisone <input type="checkbox"/> 1% <input type="checkbox"/> 2% ____ %	Betamethasone <input type="checkbox"/> 0.05% <input type="checkbox"/> 0.1%
Camphor <input type="checkbox"/> 0.25% <input type="checkbox"/> 0.5%	Aloe vera <input type="checkbox"/> 0.5% <input type="checkbox"/> 1%
Ketotifen <input type="checkbox"/> 0.05%	

Directions: Apply QID to affected area(s) (specify area) _____

Mitte: _____ grams Refill x _____

<input type="checkbox"/> Naltrexone 1%, pramoxine 1%, Tranilast 1% in XemaTop	
<input type="checkbox"/> Naltrexone 0.5%, Diphenhydramine 2%, Vitamin D3 5000IU/Gm in Xematop	
Add: Hydrocortisone <input type="checkbox"/> 1% <input type="checkbox"/> 2% ____ %	Betamethasone <input type="checkbox"/> 0.05% <input type="checkbox"/> 0.1%
Camphor <input type="checkbox"/> 0.25% <input type="checkbox"/> 0.5%	Aloe vera <input type="checkbox"/> 0.5% <input type="checkbox"/> 1%
Ketotifen <input type="checkbox"/> 0.05%	

Directions: Apply BID to affected area(s) (specify area) _____

Mitte: _____ grams Refill x _____

<input type="checkbox"/> Ketamine* <input type="checkbox"/> 1% <input type="checkbox"/> 5% <input type="checkbox"/> 10%, Amitriptyline <input type="checkbox"/> 2% <input type="checkbox"/> 5%, Lidocaine <input type="checkbox"/> 2% <input type="checkbox"/> 5% in Xematop	
Add: Hydrocortisone <input type="checkbox"/> 1% <input type="checkbox"/> 2% ____ %	Betamethasone <input type="checkbox"/> 0.05% <input type="checkbox"/> 0.1%
Camphor <input type="checkbox"/> 0.25% <input type="checkbox"/> 0.5%	Aloe vera <input type="checkbox"/> 0.5% <input type="checkbox"/> 1%
Ketotifen <input type="checkbox"/> 0.05%	

*NB: Ketamine requires M3P

Directions: Apply BID-TID to affected area(s) (specify area) _____

Mitte: _____ grams Refill x _____

Physician Signature: _____

Physician Name (Print): _____

Address / Phone: _____ / _____

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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