

TELEPHONE PRESCRIPTION

RX NO. 1

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONED BY: \_\_\_\_\_ MAY REFILL \_\_\_\_\_ (TIMES)

ORIGINAL RX. NO. \_\_\_\_\_

*Amoxicillin 500mg #60 X12  
Sig T bid BID*

Refill  Do Not Refill

DOCTOR: \_\_\_\_\_ M.D., D.D.S., D.P.M., D.O., D.V.M.

DEA NO. \_\_\_\_\_ STATE LICENSE NO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

TELEPHONE PRESCRIPTION

RX NO. 2

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONED BY: \_\_\_\_\_ MAY REFILL \_\_\_\_\_ (TIMES)

ORIGINAL RX. NO. \_\_\_\_\_

*F Metformin 500mg  
Sig T bid in AM +  
dinner #60*

Refill  Do Not Refill

DOCTOR: \_\_\_\_\_ M.D., D.D.S., D.P.M., D.O., D.V.M.

DEA NO. \_\_\_\_\_ STATE LICENSE NO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

TELEPHONE PRESCRIPTION

RX NO. 3

**R** (Please Print)

NAME: \_\_\_\_\_

ADDR: \_\_\_\_\_

PHON: \_\_\_\_\_ (TIMES)

ORIG: \_\_\_\_\_

**R**

*Calcitonin  
0.6 mg  
po tid  
#60*

4

DOC: \_\_\_\_\_ D., D.V.M.

DEA: \_\_\_\_\_ STATE LICENSE NO. \_\_\_\_\_

ADD: \_\_\_\_\_

PHC: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

TELEPHONE PRESCRIPTION

RX NO. 4

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONED BY: \_\_\_\_\_ (TIMES)

ORIGINAL RX. NO. \_\_\_\_\_

**R**

*Lithium 300  
#30  
Tid*

DOCTOR: \_\_\_\_\_ M.D., D.D.S., D.P.M., D.O., D.V.M.

DEA NO. \_\_\_\_\_ STATE LICENSE NO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

Boston Reed - Pharmacy Technician Program

Week 10 Lab - Prescription Handwriting

TELEPHONE PRESCRIPTION | RX NO. 5

NAME: *R*

ADDRESS: *Adwan 100/50*

PHONE: \_\_\_\_\_

ORIGIN: \_\_\_\_\_

*R* *1 puff BID*

*day: one dash*

DOCTOR: \_\_\_\_\_

DEA NO.: *Refill 3 times* \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

TELEPHONE PRESCRIPTION | RX NO. 7

NAME: *R*

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

ORIGIN: \_\_\_\_\_

*Soptren DS #14*

*3x: 1p, 1p, 1p*

*R*

DOCTOR: \_\_\_\_\_

DEA NO.: \_\_\_\_\_

ADDRESS: *Refill times* \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

TELEPHONE PRESCRIPTION | RX NO. 6

NAME: *R*

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

ORIGIN: \_\_\_\_\_

*ibuprofen*

*500mg TID HS*

*#60*

*Tylenol 500mg TID BID*

*#100*

DOCTOR: \_\_\_\_\_

DEA NO.:  *Leet* \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

TELEPHONE PRESCRIPTION | RX NO. 8

NAME: *R* (Please Print)

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

ORIGIN: \_\_\_\_\_

*Cherdivine*

*#9*

*5:15 daily*

*R*

DOCTOR: \_\_\_\_\_

DEA NO.: \_\_\_\_\_ STATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

TELEPHONE PRESCRIPTION RX NO. 9

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ AGE \_\_\_\_\_

Rx Retina 1/2, once  
40yr  
sy. mac h/s

REFILL 0 TIMES  
LABEL YES

DERMATOLOGY \_\_\_\_\_ M.D., D.D.S., D.P.M., D.O., D.V.M.  
STATE LICENSE NO. \_\_\_\_\_

PHONE \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

TELEPHONE PRESCRIPTION RX NO. 11

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Address \_\_\_\_\_ Date \_\_\_\_\_

Androjel 5gm  
q. ii qd (qd)  
#60

Refill NR 1 2 3 4 5  
Void after 12/10 1-10

1-24  
 25-49  
 50-74  
 75-100  
 101-150  
 151 and over  
Units

Do Not Substitute-Dispense As Written

\_\_\_\_\_ M.D., D.D.S., D.P.M., D.O., D.V.M.  
STATE LICENSE NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_  
PHONE \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

TELEPHONE PRESCRIPTION RX NO. 10

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

Rx Regip 0.25mg  
Disp #30  
S/S & H/S

Date 8/10

1-24  
 25-49  
 50-74  
 75-100  
 101-150  
 151 and over  
Units

REFILL 0 TIMES

DOCTOR \_\_\_\_\_ M.D., D.D.S., D.P.M., D.O., D.V.M.  
DEA NO. \_\_\_\_\_ STATE LICENSE NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_  
PHONE \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

1 Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND DATE 11/1/05

Rx # 12

N  
AI  
PI  
O  
] Valisone art  
0.1%

4  
S/S: Apply red  
to upper neck

REFILL 1 TIMES

DO NOT SUBSTITUTE

To ensure brand name dispensing, check PHARMACIST: \_\_\_\_\_

**TELEPHONE PRESCRIPTION** RX NO. 13

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONED BY: \_\_\_\_\_ MAY REFILL: 1

*Cefinplacem 500mg*  
*slk*  
*3 ÷ BID x 7d*

1-24  
 25-49  
 50-74  
 75-100  
 101-150  
 151 and o

1 2 3 4 5

DOCTOR: \_\_\_\_\_ M.D. D.D.S. D.P.M. D.O. D.V.M.

DEA NO. \_\_\_\_\_ STATE LICENSE NO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

**TELEPHONE PRESCRIPTION** RX NO. 15

DATE: \_\_\_\_\_

*25mg per Virginia*  
*Seroguel to us 7/3/13*  
*#60*  
*Rx verified*  
*in Patel*  
*11/14/15*

Refill:  Do Not Refill:

Pharmacist: Use Brand Only \_\_\_\_\_ M.D. \_\_\_\_\_ M.D. D.D.S. D.P.M. \_\_\_\_\_ M.D.

STATE LICENSE NO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

**TELEPHONE PRESCRIPTION** RX NO. 14

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

	Strength	Amount	Refills
<i>Fefo 325g</i>		<i>10</i>	<i>7</i>
<i>7 po bid</i>			
<i>Protonix 40mg</i>		<i>30</i>	<i>7</i>
<i>7 po qd</i>			

DOCTOR: *[Signature]* M.D. \_\_\_\_\_ M.D.

DEA NO. \_\_\_\_\_ Dispense as Written \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHARMACIST: \_\_\_\_\_

**TELEPHONE PRESCRIPTION** RX NO. 16

Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

NAME: *R*

ADDRESS: *Elindia*

PHONE: \_\_\_\_\_

ORIGIN: *R*

*30d*

*Esophageal Med*

*+ coffee, Alca*

DOCTOR: \_\_\_\_\_

DEA NO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

Refill: *21* times

DO NOT SUBSTITUTE

To ensure brand name dispensing, r