OKLAHOMA DEPARTMENT OF CORRECTIONS
PRACTITIONER CARDS
INVENTORY and REORDER FORM
FAX: 1-800-523-0008

MUST BE SIGNED BY, AND ISSUED BY, THE PHYSICIAN or DENTIST

*****please use fax cover sheet when faxing order*****

CONTRACT PHARMACY VENDOR: _____

FACILITY NAME/CODE NAME: _____ **DATE:** _____

MEDICATIONS	DIRECTIONS	REORDER RX#	MAX QUANTITY	QUANTITY ON HAND	QUANTITY REQUESTED
LEVALBUTEROL INHALER	Use 1-2 puffs every 4 hours as needed.				
AMOXICILLIN 500mg #30	Take 1 cap 3 times a day till gone.				
CEPHALEXIN 500mg #30	Take 1 cap 3 times a day till gone.				
CLINDAMYCIN 150 MG # #30	Take 2 caps every 8 hours for 10 days				
DIFLUCAN 150MG #1	Take 1 tablet as directed				
DOXYCYCLINE 100mg #20	Take 1 tab 2 times a day till gone.				
ERYTHROMYCIN 333mg #30	Take 1 tab 3 times a day till gone.				
IBUPROFEN 600mg #30	Take 1 tab 3 times a day as needed. **Take with food**				
IBUPROFEN 800mg #30	Take 1 tab 3 times a day as needed. ** Take with food**				
MELOXICAM 15mg #30	Take 1 tab daily **Take with Food**				
METRONIDAZOLE 250mg #30	Take 2 tabs 2 times a day till gone.				
NAPROXEN 500 mg #30	Take 1 tab twice a day **Take with Food**				
PENICILLIN VK 500mg #30	Take 1 tab 3 times a day till gone.				
PREDNISONE 10mg DOSEPAK	Take as directed on package till gone.				
SULFAMETH/TRIMETH DS 800mg/160mg #20	Take 1 tab 2 times a day till gone.				

Ordered By:(Print) _____ **Date:** _____

Signature: _____ **Title:** _____