Clinic Name: _____
Address: _____

Phone#: _____ Fax#: _____

Doctor's Name: _____
DEA#: _____
License#: _____

Patients Name:
Address: **D.O.B:**

PAIN MEDICATION

				REF:

MUSCLE RELAXANT MEDICATION:

				REF:

ANTI-INFLAMMATORY MEDICATIONS:

				REF:

ULCER MEDICATION:

				REF:

SLEEP MEDICATION:

				REF:

ADDITIONAL REQUESTED MEDICATIONS:

TRANSDERMAL

MUSCLE RELAXANT

Approved By: _____ **Date:** _____

For Doctor: _____ **Doctor's Signature:** _____

Based on the patient's condition, symptoms and diagnosis and in compliance with title 8, California code of regulations 4600 (B) I hereby notify that the prescribed Medical prescription is medically necessary to relieve patient's symptoms caused by his or her condition.