PATIENT _____

ADDRESS _____

_____

ALLERGIES _____

DATE _____ DOB _____

DAYTIME PHONE _____

WARTpeel® (5fu, sal acid) in Remedium™ Delivery System

Must be dispensed in an amber syringe to ensure quality

of medication

SIG: Apply once daily following instruction sheet.

DISP: 5gm.

REFILL: _____

SIGNATURE: _____

PRINTED NAME: _____

PHONE _____

_____ DEA

CLINIC _____

FAXED BY: _____

NAME TITLE