

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 a day following instruction sheet.

DISP: 5gm.

INDICATION: Warts SKs Genital Warts Molluscum

REFILL: _____

SIGNATURE: _____

PRINTED NAME: _____

PHONE: _____

NPI: _____

CLINIC: _____