PATIENT: ______________________________________________

ADDRESS: ______________________________________________

______________________________________________

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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

REFILL: ____________________

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SIGNATURE: ______________________________________________

PRINTED NAME: ___________________________________________

PHONE: _________________________________________________

NPI: ____________________________________________________

CLINIC: _________________________________________________