MYERLEE
PHARMACY

Veins

Patient Name: _____ Date: _____

Address: _____

City: _____State: _____Zip:_____

Date of Birth: _____Phone:_____

Allergies: _____

- Sodium Tetradecyl Sulfate Injection 2% 30cc
  QTY: _____

- Glycerin Injection 72% 30cc
  QTY: _____

- Laureth-9 (Polidocanol) 1% 30 cc
  QTY: _____

- Laureth-9 (Polidocanol) 3% 30 cc
  QTY: _____

Other: _____
QTY: _____
SIG: _____

Physician Signature: _____

Physician Name: _____License #: _____

Physician Address: _____

Telephone: _____Facsimile: _____