



Compounded Formulas for Oral Candida Rx Template

Patient's Name: _____ DOB: _____

Patient's Address: _____ City: _____ State _____, Zip: _____

Patient's Phone: _____ Drug Allergies: _____

Formulation Selection (choose one by checking the corresponding box)

☐

Amphotericin B 100mg/mL Oral Rinse

☐

Nystatin 100,000 U/mL-Triamcinolone Acetonide 0.2% SF Oral Rinse

Quantity Selection (choose a dispense quantity by checking the corresponding box)

☐

120mL

☐

240mL

☐

480mL

☐

____ mL

Directions for Use (Choose pre-worded directions below or manually enter directions for use)

☐

Gargle and swish 5mL for 30-60 seconds, then spit. Perform up to every 4 hours as needed. Do not swallow medication

☐

Refills?

☐

Refill _____ time(s)

☐

No Refills

Prescriber's Name: _____ Date: _____

Prescriber's Street Address: _____ City: _____ State: _____ Zip: _____

Prescriber's Phone Number: _____ Name of person submitting order: _____