

Tache Pharmacy at Seven Oaks Hospital
2300 McPhillips Street
Winnipeg, MB
R2V 3M3

Ph #: (204) 633-2233 Fax #: (204) 633-2244

Patient: _____ PHIN: _____

Address: _____ DOB: _____

Phone: _____ Date: _____

Popular combinations:

- Pink Lady – Xylocaine Viscous 2%: Diovol Plus, 1:1
- Modified Pink Lady – Xylocaine Viscous 2%: Diovol Plus: Benadryl Elixir, 1:1:1
- Xylocaine Viscous 2%, Diovol Plus, Benadryl Elixir, Nystatin 100 000U/mL, Prednisolone 1mg/mL, Distilled Water – all equal parts
- Magic Mouthwash – diphenhydramine 0.075%, hydrocortisone 0.125%, nystatin 7500U/mL, lidocaine 0.4%
- Super Magic Mouthwash – diphenhydramine 0.125%, dexamethasone 0.00033%, tetracycline 1.25%, lidocaine 1%
- Tetracaine 0.5%, hydrocortisone 1%, clotrimazole 2%, sucralfate 15.6%
- Ketamine 0.03%, tetracaine 0.5%, sucralfate 15.6% (requires a duplicate rx)

Check the Ingredient & Strength:

- | <u>Check the Ingredient & Strength:</u> | <u>Other Strength:</u> |
|---|------------------------|
| <input type="checkbox"/> Ketamine _____ 0.03% (requires a duplicate Rx) | _____ % |
| <input type="checkbox"/> Gabapentin _____ 6% | _____ % |
| <input type="checkbox"/> Lidocaine _____ 0.4% _____ 1% _____ 2% | _____ % |
| <input type="checkbox"/> Tetracaine _____ 0.5% _____ 1% | _____ % |
| <input type="checkbox"/> Diphenhydramine _____ 0.075% _____ 0.125% _____ 0.2% | _____ % |
| <input type="checkbox"/> Hydrocortisone _____ 0.125% _____ 0.5% _____ 1% | _____ % |
| <input type="checkbox"/> Dexamethasone _____ 0.00033% | _____ % |
| <input type="checkbox"/> Sucralfate _____ 15.6% | _____ % |
| <input type="checkbox"/> Clotrimazole _____ 2% | _____ % |
| <input type="checkbox"/> Nystatin _____ 7500 U/mL | _____ % |
| <input type="checkbox"/> Tetracycline _____ 1.25% | _____ % |
| <input type="checkbox"/> Misoprostol _____ 0.0024% | _____ % |
| <input type="checkbox"/> Additional ingredients: _____ % _____ % | _____ % |

Flavour (if applicable): Bubble Gum Grape Unflavoured Other (please specify): _____

Directions: Swish and spit 10-15mL or _____ mL q 2-3 hours or _____ (frequency) as needed

OR Swish and swallow _____ mL _____ (frequency) as needed.

(Consider systemic effects when determining volume and frequency if swallowing)

Mitte: _____ mL Refill x _____ **Expiry date is typically 30 days in the fridge

Physicians Name (PRINT): _____

Address: _____

Phone #: _____

Signature X _____ License #: _____

Prescription Certification: This prescription represents the original of the prescription. The pharmacy addressee noted above is the only intended recipient and there are no other. The original prescription has been invalidated and securely filed and it will not be transmitted elsewhere at another time. THE TELECOPY IS CONFIDENTIAL AND IS INTENDED TO BE RECEIVED BY THE ADDRESSEE ONLY. IF THE READER IS NOT THE RECIPIENT THEREOF, YOU ARE ADVISED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS FACSIMILE IS STRICTLY PROHIBITED.