

Compounding Order Form

Poop Goop

These are our most prescribed options, we can always work with providers and patients to personalize treatment. Please feel free to call with questions or substitutions.

Patient Name:	_____
DOB:	_____
Phone:	_____
Address:	_____

- CHOLESTYRAMINE/AQUAPHOR** (OINTMENT)
- CHOLESTYRAMINE/NYSTATIN/AQUAPHOR** (OINTMENT)
- CHOLESTYRAMINE/NYSTATIN**
- CHOLESTYRAMINE/NYSTATIN/HYDROCORTISONE 2.5%**
- NYSTATIN/KARAYA GUM/DESITIN/MINERIN**
- NYSTATIN/KARAYA GUM/DESITIN/MINERIN/HYDROCORTISONE 2.5%**

Directions: _____

Quantity (circle one): 30gm 60gm 90gm alternative amount: _____

****Note: We call patients with price options before filling.**

Provider name:	_____				
Provider Signature:	_____				
Refills:	_____	NPI:	_____	Date:	_____