JUST
$1.00
per DOSE!

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SILDENAFIL Rx ORDER FORM

OFFICE INFORMATION

Prescriber name: ______________________ Phone: ______________________

Address: ______________________ City: ______________________

State: ______________ Zip: ____________ NPI: ______________________

PATIENT INFORMATION

Patient name: ____

Address: ____

City: ______________________ State: ______________________

Zip: ______________________ DOB: ______________________

Phone: ______________________ Email: ______________________

Rx: Sildenafil 20mg

Sig: Take 1 to 5 tablets by mouth 1 hour prior to sexual activity

Refill: ____

Prescriber Signature: ____

Date: ____

Thank You!