Clayton Central Pharmacy
Compounding Services

Topical Pain Management
Order Form

Doctor Name: _____
Prescriber Number: _____
Address: _____
_____
Phone number: _____ Fax: _____

Patient Name: _____
Address: _____
_____
Allergies: _____
Phone number: _____

Common Formulations: **Cross out any unwanted medications if not desired**

ANTI-INFLAMMATORY CREAMS
_____ DICLOFENAC 3% BACLOFEN 2% (ARTHRITIS-TENDONITIS-PLANTAR FASCITIS-EPICONDYLITIS)
_____ DICLOFENAC 3% BACLOFEN 2% TETRACAINE 2% (MUSCULOSKELETAL)
_____ KETOPROFEN 20% (MUSCULOSKELETAL, ARTHRITIS-TENDONITIS-PLANTAR FASCITIS)

NEUROPATHIC PAIN CREAMS
_____ KETAMINE 10%-BACLOFEN 2%-GABAPENTIN 6%-LIDOCAINE 5%
_____ KETAMINE 10%-CLONIDINE 0.2%-GABAPENTIN 6%-IMIPRAMINE 3%-TETRACAINE 2% (RSD/CRPS-TRIGEMINAL NEURALGIA-PHANTOM LIMB PAIN-DEVELOPING NEUROPATHY)
_____ KETAMINE 10%-BACLOFEN 2%-GABAPENTIN 6%-IMIPRAMINE 3%-NIFEDIPINE 2%-TETRACAINE 2% (DIABETIC & CHEMOTHERAPY INDUCED PERIPHERAL NEUROPATHY)

COMBINATION PAIN CREAMS
_____ DICLOFENAC 3%-BACLOFEN 2%- GABAPENTIN 6%-TETRACAINE 2% (TMJ, MUSCULOSKELETAL PAIN/INFLAMMATION)
_____ KETAMINE 10%-BACLOFEN 2%- DICLOFENAC 3%-GABAPENTIN 6%-TETRACAINE 2% (RADICULOPATHY, FIBROMYALGIA)
_____ DICLOFENAC 3%-BACLOFEN 2% GABAPENTIN 6%-ORPHENIDRINE 5%-TETRACAINE 2% (MYOFASCIAL PAIN SYNDROME)
_____ KETAMINE 10%- DICLOFENAC 3%-GABAPENTIN 6%-TETRACAINE 2% BACLOFEN 2% (FAILED BACK SYNDROME)

Quantity (circle one): 50g 100g Repeats: _____

Prescribers Signature: _____ Date: _____

Please fax completed form to:
Clayton Central Pharmacy (Pharmasave)
(03) 9544 0124
(Please give original script to patient)