



Prescription Fax Form

Patient Name: _____ Date: _____
Shipping Address: _____
(No P.O. Boxes)
City, State, Zip: _____
Phone: _____ Country _____

Physician Name: _____ DEA# _____
Please Print
Physician Signature: _____ Phone #: _____

CAL-DETOX System (30-day Supply) – 30 count EDTA Suppositories, 150 count CAL-DETOX Oral Supplements and 500 mg Tetracycline HCl #30
(Usual Program Duration is 4-6 months)

Order Quantity: ___ 1 Month ___ 2 Mo. ___ 3 Mo. ___ 4 Mo. ___ 5 Mo. ___ 6 Mo.

Pricing: 1-5 Units (30 day supply) \$285.00 per Unit, or 6 or more Units @ \$260.00 ea.

Order Quantity _____ X \$ _____ .00 per Unit = \$ _____ .00 + Shipping and Handling
(3 or more Units ship free US ground.)

Payment info:

Visa Master Card American Express Discover

Name as it appears on card _____

Credit Card # _____ Expiration _____
(Month / Year)

Security Code _____ Cardholder Phone Number _____

Signature _____

Credit Card Billing Address: _____
(If different from shipping address)

City State, Zip: _____

Instructions: Fax completed form to: 813-925-8933

*11669 Countryway Blvd
Tampa, FL 33626*

PHONE - 813-925-8200 FAX 813-925-8933

www.westchasepharmacy.com

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