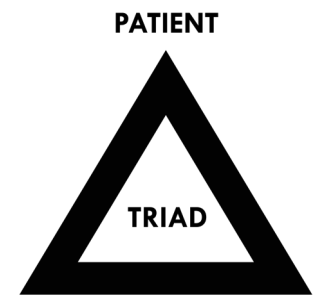


LDN (Low Dose Naltrexone) COMPOUNDS

Patient Name: _____ DOB: ____/____/____
 Address: _____ City: _____
 State: _____ Zip: _____ Cell: (____) _____ Home: (____) _____
 Email: _____



Alternate Starter Dose:
LDN (Low dose Naltrexone) Capsules

Week 1 & 2: Take 1.5mg Capsule by mouth daily for 14 days.
Week 3 & 4: Take 2 Capsules (1.5mg) by mouth daily for 14 days.
Week 5: Take 3 Capsules (1.5mg) by mouth daily for 7 days.
 If no side effects are present, you are ready to begin your maintenance dose of 4.5mg. If you are experiencing side effects you may want to call your provider and have them adjust your dose.

Qty: 63 Capsules Refills: _____

Common Starter Dose
LDN (Low dose Naltrexone) Capsules

Week 1: Take 1mg Capsule by mouth daily for 7 days.
Week 2: Take 2mg Capsule by mouth daily for 7 days.
Week 3: Take 3mg Capsule by mouth daily for 7 days.
Week 4: Take 4mg Capsule by mouth daily for 7 days.
 Then stay on 4mg for maintenance dose.

QTY: 28 Refills: _____

LDN (Low dose Naltrexone) Capsules
(Circle dose)

0.5mg 1mg 1.5mg 2mg 2.5mg 3mg 3.5mg 4mg 4.5mg
 Sig: Take 1 capsule by mouth daily.

QTY: 30 60 90 120 Refills: _____

LDN (Low Dose Naltrexone) 2mg/ml Solution

Sig: Take ____ ml by mouth every day. Note * If this is your starter therapy, stay on current dose for 1 week or until there are no side effects, then titrate up by 0.5mg (0.25ml). Targeted dose is no more than 4.5mg (2.25ml)

Qty: 70ml (Check for Starter Therapy)

QTY: 30ml 60ml 90ml 120ml Refills: _____

LDN (Low Dose Naltrexone) ____mg/ml Solution

Sig: Take ____ ml by mouth daily.

QTY: 30ml 60ml 90ml 120ml

LDN (Low Dose Naltrexone) 4mg RDT's (circle dose)

Sig: Place 1/4 or 1/2 or 1 RDT under the tongue every day. Do not eat or drink anything for 30 minutes before or after.

QTY: 30 60 90 120 Refills: _____

NOTES: _____

Providers:

When patients are beginning on LDN therapy, remember to **start low and go slow**. If patients experience side effects and they still have them at the end of that weekly dose, do not move up to the next dose until side effects are gone. Patient compliance is essential in order to reach maximum benefit.

Physician Approval

Provider Name: _____ DEA: _____
 Address: _____ Suite: _____
 City: _____ State: _____ Zip: _____
 Phone: (____) _____ Fax: (____) _____ Email: _____
 Provider Signature: _____ Date: ____/____/____

Charge: ____physician ____patient
Ship: ____physician ____patient
Shipping: ____Pick-up ____Regular Mail
 ____UPS Ground