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:** _____

☐ **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) ____mg/ml Solution**

Sig: Take _____ ml by mouth daily.

QTY: 30ml 60ml 90ml 120ml

☐ **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) 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) 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:** _____

PATIENT
TRIAD
PHYSICIAN PHARMACY

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