



CENTRAL MISSOURI PHYSICAL THERAPY

Jefferson City, MO 65101
Moberly, MO 65270

Patient Name: _____ Date: _____

Address: _____

Rx CPD **Dexamethasone Sod Phosphate 0.4% Soln** Size: 20 ml Refill: 1 2 3 4 5 PRN

Dexamethasone Sod. Phos. 80 mg *Ref: CPD DEX 0.4%*
Water Dist qs 20ml

Label: Only for use with Iontophoresis. NOT for oral administration or for injection.

_____, _____
Substitution Permitted Physician

Patient Name: _____ Date: _____

Address: _____

Rx CPD **Hydrocortisone 5% USP in Eucerin Cream** Size: 400 gm Refill: 1 2 3 4 5 PRN

Hydrocortisone acetate, USP, Mico 20 grams *Ref: CPD 5% HC MICRO*
Eucerin or similar cream base qs 400 grams

Label: Caution: High Potency Formulation. For External Use Only.

_____, _____
Substitution Permitted Physician

Patient Name: _____ Date: _____

Address: _____

Rx CPD **Hydrocortisone 5% USP in Eucerin Cream** Size: 400 gm Refill: 1 2 3 4 5 PRN

Hydrocortisone acetate, USP, Mico 20 grams *Ref: CPD 5% HC MICRO*
Eucerin or similar cream base qs 80 grams

Label: Caution: High Potency Formulation. For External Use Only.

_____, _____
Substitution Permitted Physician