

Rep Name: _____



New Order/Prescription Fax Form

FAX NUMBER: _____

STEP 1

COMPLETE
PATIENT
INFO

Patient Name _____
 Cell Phone # () - Date of Birth / /
 Email _____
 Street Address _____
 City _____ State _____ Zip _____

STEP 2

SELECT
PRODUCT

Peripheral Neuropathic Complications

☐ **EB-N3** 6mg L-methylfolate Calcium, 4mg Methylcobalamin, 70mg Pyridoxal 5-Phosphate
Sig 1 capsule PO QD **Qty** #90 Capsules (3 month supply)
Other Sig **Refills** ☐ Auto Fill or other ☐ _____



☐ **EB-N5** 3mg L-methylfolate Calcium, 2mg Methylcobalamin, 35mg Pyridoxal 5-Phosphate, 300mg Alpha Lipoic Acid, 2500 IU Vitamin D3
Sig 2 capsules PO QD **Qty** #180 Capsules (3 month supply)
Other Sig **Refills** ☐ Auto Fill or other ☐ _____



Central Nervous System Disorders

☐ **EB-P1** 15mg L-methylfolate Calcium
Sig 1 capsule PO QD **Qty** #90 Capsules (3 month supply)
Other Sig **Refills** ☐ Auto Fill or other ☐ _____



☐ **EB-C3** 6mg L-methylfolate Calcium, 2mg Methylcobalamin, 600mg N-Acetyl L-Cysteine
Sig 1 capsule PO QD **Qty** #90 Capsules (3 month supply)
Other Sig **Refills** ☐ Auto Fill or other ☐ _____



Migraines and Headaches

☐ **EB-H4** 200mg Riboflavin, 50mg Co Q10, 0.2mg L-methylfolate Ca, 175mg Magnesium Bisglycinate
Sig 2 capsules PO QD **Qty** #180 Capsules (3 month supply)
Other Sig **Refills** ☐ Auto Fill or other ☐ _____



Bone and Soft Tissue Healing

☐ **EB-S4** 1200mg Calcium Citrate, 500mg Magnesium Bisglycinate TRAACS, 10,000IU Cholecalciferol, 50mg Zinc Bisglycinate Chelate TRAACS
Sig 1 capsule TID with food **Qty** #270 Capsules (3 month supply)
Other Sig **Refills** ☐ Auto Fill or other ☐ _____



STEP 3

COMPLETE
PROVIDER
INFO

FAX TO

HCP Name	NPI # (Required)	License #	HCP Name	NPI # (Required)	License #
☐ _____	_____	_____	☐ _____	_____	_____
☐ _____	_____	_____	☐ _____	_____	_____

Office Contact Name _____ Phone _____ Fax _____
 Address _____ City _____ State _____ Zip _____

SIGNATURE

Signature or Stamp Acceptable

Date

FAX:

Phone: 1-636-614-3152

Email: support@EBMmedical.com

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