WELLNESS PHARMACY OF LINCOLN

4640 Champlain Drive #113
Lincoln, NE 68521

Phone: (402) 413-9950
FAX: : (402)413-9964
**** 27th & Superior St****

Provider Information
Provider Name:____.
Address:____.
Phone:____.

Patient Information
Patient Name:______________________**Birthday**:______________Phone______________

Address:____

LOW DOSE NALTREXONE PROTOCOL - CAPSULES

*****Check boxes and change quantity as preferred**

	Dose	Quantity	Refill		Dose	Quantity	Refill
❏	0.15mg	1 qhs # _15__	Refill # ____	❏	5 mg	1 qhs #_30__	Refill # ____
❏	0.25mg	1 qhs # _15__	Refill # ____	❏	5.5 mg	1 qhs # _30__	Refill # ____
❏	0.5mg	1 qhs # _15__	Refill # ____	❏	6 mg	1 qhs # _30__	Refill # ____
❏	1 mg	1 qhs # _30__	Refill # ____	❏	6.5 mg	1 qhs # _30__	Refill # ____
❏	1.5mg	1 qhs # _30__	Refill # ____	❏	7 mg	1 qhs # _30__	Refill # ____
❏	2 mg	1 qhs # _30__	Refill # ____	❏	7.5 mg	1 qhs # _30__	Refill #____
❏	2.5mg	1 qhs # _30__	Refill # ____	❏	8 mg	1 qhs # _30__	Refill # ____
❏	3 mg	1 qhs # _30__	Refill # ____	❏	8.5 mg	1 qhs # _30__	Refill # ____
❏	3.5 mg	1 qhs # _30__	Refill # ____	❏	9 mg	1 qhs # _30__	Refill # ____
❏	4.0 mg	1 qhs # _30__	Refill # ____	❏	9.5 mg	1 qhs # _30__	Refill # ____
❏	4.5 mg	1 qhs # _30__	Refill # ____	❏	10 mg	1 qhs # _30__	Refill # ____

****EACH CAPSULE CONTAIN *450MG MAGNESIUM GLYCINATE* AS FILLER**
**PLEASE SELECT IF ANOTHER FILLER IS PREFERRED: *Microcrystalline Cellulose / Loxoral*

OTHER OPTIONS:

CIRCLE ONE: ***Oral Solutions / Sublingual drops / Transdermal Cream / Troche***

❏ *Starting dose:__________QHS. **INCREASE** by ½ mg or as tolerated every ________weeks*

❏ *Maintenance dose:__________________QHS Refills:________*

OTHER:

Provider's Signature:______________________________________Date:________________