Patient Information:
- Name: [Patient's Full Name]
- Date of Birth: [MM/DD/YYYY]
- Address: [Patient's Address]
- Phone Number: [Patient's Phone Number]
Prescriber Information:
- Name: [Prescriber's Full Name]
- Title: [e.g., MD, DO, NP]
- Practice Name: [Practice/Clinic Name]
- Address: [Practice Address]
- Phone Number: [Practice Phone Number]
- NPI Number: [National Provider Identifier]
Date of Prescription:
- [MM/DD/YYYY]
Medication Information:
- Medication Name: Vyvanse
- Dosage: [e.g., 30 mg, 50 mg]
- Route: Oral
- Quantity: [Number of Capsules/Tablets]
- Refills: [Number of Refills Authorized]

Indication:
- [Diagnosis or reason for prescription]
Instructions:
- [Dosage schedule, e.g., Take one capsule daily in the morning]
Side Effects:
- [Brief mention of common side effects]
Follow-up Appointment:
- [Date/Time of the next follow-up, if applicable]
Prescriber Signature:
- _____
- [Prescriber's Full Name, Credentials]
- [Date of Signature]
Additional Notes:
- [Any other relevant information or instructions]