FEMALE BIO-IDENTICAL HORMONE THERAPY ORDER FORM

All compounds for clinical use require a prescription written for each individual patient. Medication will be dispensed with patient specific label and in patient specific package.

PATIENT INFORMATION

Patient name: _____ DOB: _____

Address: _____ Phone: _____

Allergies: _____ Relevant diagnosis / indication: _____

PRESCRIBER INFORMATION

Prescriber name: _____ NPI: _____ DEA: _____

Address: _____ Phone: _____ Fax: _____

*** Commonly prescribed hormones and doses; not an all-inclusive list ***

ESTROGEN

Quantity: _____ OR
Day Supply: ☐ 30 ☐ 60 ☐ 90
Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ __
Directions: _____

HORMONE
☐ Bi-Est 80/20 (Estriol/Estradiol)
☐ Bi-Est 50/50 (Estriol/Estradiol)
☐ Estradiol
☐ Estriol
☐ Other: _____

DOSAGE FORM
☐ Topical cream
☐ Vaginal cream
☐ Other: _____

STRENGTH
Estradiol: _____ mg/g
Estriol: _____ mg/g
Total Bi-Est: _____ mg/g
Per unit: _____ mg
Other: _____

FREQUENCY
☐ Daily
☐ Other: _____

SITE
☐ Upper arm
☐ Inner forearm
☐ Thigh / buttock
☐ Vaginal
☐ Other: _____

PROGESTERONE

Quantity: _____ OR
Day Supply: ☐ 30 ☐ 60 ☐ 90
Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ __
Directions: _____

DOSAGE FORM
☐ SR oral capsule
☐ Topical cream
☐ Other: _____

STRENGTH
☐ 50 mg
☐ 100 mg
☐ 150 mg
☐ 200 mg
☐ _____ mg/capsule
☐ _____ mg/g

REGIMEN
☐ Nightly
☐ Cyclic: days ____ to ____
☐ _____ times weekly
☐ Other: _____

TESTOSTERONE

Quantity: _____ OR
Day Supply: ☐ 30 ☐ 60 ☐ 90
Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ __
Directions: _____

DOSAGE FORM
☐ Topical cream
☐ Topical gel
☐ Vaginal cream
☐ Other: _____

STRENGTH
☐ 1 mg/g
☐ 2 mg/g
☐ 4 mg/g
☐ 10 mg/g
☐ _____ mg/g
☐ _____ mg/unit

FREQUENCY
☐ Daily
☐ Other: _____

SITE
☐ Upper arm
☐ Inner forearm
☐ Thigh / buttock
☐ Vaginal
☐ Other: _____

DHEA

Quantity: _____ OR
Day Supply: ☐ 30 ☐ 60 ☐ 90
Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ __
Directions: _____

DOSAGE FORM
☐ IR Oral capsule
☐ SR Oral capsule
☐ Topical cream
☐ Vaginal cream
☐ Other: _____

STRENGTH
☐ 2.5 mg
☐ 5 mg
☐ 10 mg
☐ 25 mg
☐ 50 mg
☐ _____ mg/g

FREQUENCY
☐ Daily
☐ Nightly
☐ _____ times weekly
☐ Other: _____

COMBINATION PRODUCT OR OTHER PRESCRIPTIONS

Ingredients / strengths / dosage form: _____

Complete SIG / special instructions: _____

Quantity or Day Supply: _____ Refills: _____

PRESCRIBER AUTHORIZATION

Prescriber signature: _____ Date: _____