




<b>Patient Information:</b>			PLEASE FAX: Patient Demographic Sheet & Prescription Insurance Card if available.
FIRST NAME:	LAST NAME:	DATE OF BIRTH:	
PRIMARY PHONE #:	SECONDARY PHONE #:	DRIVER'S LICENSE (if CII, CIII or CIV):	
ADDRESS:	CITY, STATE, ZIP:	ALLERGIES:	

<b>Rx Medication Order:</b>	<b>Pharmacist Please Compound:</b>	<i>Prescriber: You may change the directions, or delete / substitute / add any additional medications for all formulations.</i>
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<b>Estrogen</b> <input type="checkbox"/> Bioestrogen (80/20 E3/E2 ) Topical per 0.1ml Lipoderm (in micropen) (circle one) <input type="checkbox"/> Combine with testosterone 0.625mg 1mg 1.25mg 1.5mg 1.75mg 2mg 2.5mg ___mg	SIG <input type="checkbox"/> Apply 0.1ml to skin, once daily. <input type="checkbox"/> Sunday off Dispense: ___ days supply Refills: ___
<b>Progesterone</b> <input type="checkbox"/> Capsules 50mg 75mg 125mg 100mg 150mg 175mg ___mg <input type="checkbox"/> Cream per 1ml 25mg 50mg 75mg 100mg 150mg <input type="checkbox"/> Slow release capsules (E4M)	SIG <input type="checkbox"/> Take one capsule by mouth, once daily. <input type="checkbox"/> Apply 1ml to skin, at bedtime. <input type="checkbox"/> Sunday off Dispense: ___ days supply Refills: ___
<b>Pregnenolone</b> <input type="checkbox"/> Pregnenolone capsules 10mg 15mg 25mg 50mg ___mg	SIG <input type="checkbox"/> Take one capsule by mouth, once daily. Dispense: ___ days supply Refills: ___
<b>DHEA</b> <input type="checkbox"/> Capsules 2.5mg 5mg 10mg 25mg ___mg <input type="checkbox"/> Combine DHEA and Pregnenolone (please select dosage for each individually and we will combine) <input type="checkbox"/> Cream 5mg/gm ___mg/gm	SIG <input type="checkbox"/> Take one capsule by mouth, once daily. <input type="checkbox"/> Apply 1ml (2 pumps) to inner thigh, once daily. Dispense: ___ days supply Refills: ___
<b>Testosterone</b> <input type="checkbox"/> Testosterone topical per 0.1ml Lipoderm (in micropen) 0.5mg 1mg 1.5mg 2mg 4mg ___mg	SIG <input type="checkbox"/> Apply 0.1ml to skin, once daily. Dispense: ___ days supply Refills: ___
<b>Vaginal Products</b> <input type="checkbox"/> Estradiol 0.01% cream <input type="checkbox"/> Estriol ___mg/gm <input type="checkbox"/> DHEA suppositories 6.5mg 13mg <input type="checkbox"/> Hyaluronic Acid suppositories 5mg	SIG <input type="checkbox"/> Insert 1gm or suppository vaginally for 14 days, then 2-3x per week. <input type="checkbox"/> Use 1 supp vaginally, at bedtime. Dispense: ___ days supply Refills: ___

**(OPTIONAL) ADDITIONAL INSTRUCTIONS OR COMPOUNDS:**

<input type="checkbox"/> Dispense in Topi-click (4 clicks = 1ml) 	<input type="checkbox"/> Dispense in micropen (2 clicks = 0.1ml) 	<input type="checkbox"/> Dispense in pump (2 pumps = 1ml) 
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<b>Prescriber Information:</b>
Printed name:
Phone number:
<b>PRESCRIBER'S SIGNATURE:</b>
NPI# or DEA# (CTP# for CNPs only):
DATE:

<b>Contact Information:</b>