



Patient Information:			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:			

Rx Medication Order:	Pharmacist Please Compound:	<i>Prescriber: You may change the directions, or delete / substitute / add any additional medications for all formulations.</i>
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Estrogen	<input type="checkbox"/> Bi-Estrogen (80/20 E3/E2) Topical per gram (circle one) 0.625mg 1mg 1.25mg 1.5mg 1.75mg 2mg 2.5mg ____mg <input type="checkbox"/> Combine with testosterone <input type="checkbox"/> Combine with progesterone	SIG <input type="checkbox"/> Apply 1 gram to skin, once daily. Dispense: ____ days supply Refills: ____
Progesterone	<input type="checkbox"/> Capsules 50mg 75mg 125mg 100mg 150mg 175mg ____mg <input type="checkbox"/> Cream per gram 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 1 gram to skin, at bedtime. Dispense: ____ days supply Refills: ____
Pregnenolone	<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: ____
DHEA	<input type="checkbox"/> DHEA Capsules 2.5mg 5mg 10mg 25mg ____mg <input type="checkbox"/> Combine DHEA and Pregnenolone (please select dosage for each individually and we will combine)	SIG <input type="checkbox"/> Take one capsule by mouth, once daily. Dispense: ____ days supply Refills: ____
Testosterone	<input type="checkbox"/> Testosterone topical per gram 0.5mg 1mg 1.5mg 2mg 4mg 5mg ____mg	SIG <input type="checkbox"/> Apply 1 gram to skin, once daily. Dispense: ____ days supply Refills: ____
Vaginal Products	<input type="checkbox"/> Estradiol 0.01% cream <input type="checkbox"/> Estriol (circle one) 0.5mg 1mg 2mg <input type="checkbox"/> DHEA suppositories (circle one) 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 pump (2 pumps = 1gram) 
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Prescriber Information:	Contact Information:
Printed name: Phone number: PRESCRIBER'S SIGNATURE: NPI# or DEA# (CTP# for CNPs only): _____ DATE: _____	