

HORMONE THERAPY OPTIONS COMPOUNDED PRESCRIPTION REQUEST FORM

Patient Full Name: _____ Date of Birth: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alternate Phone : _____
 Insurance Info: *Please attach copy of patients' insurance card(s), including RX card, when faxing*

ESTROGEN ONLY

<input checked="" type="checkbox"/>	BIOIDENTICAL	%			FORM
		E1	E2	E3	
	ESTRADIOL (E2)				CREAM
	ESTRIOL (E3)				CREAM
	BI-ESTROGEN (E2E3): Common dosage: 20% Estradiol + 80% Estriol				CREAM
	TRI-ESTROGEN (E1E2E3): Common dosage: 10% Estrone+10% Estradiol + 80% Estriol				CREAM

PROGESTERONE ONLY

<input checked="" type="checkbox"/>	BIOIDENTICAL	P4 %	FORM
	PROGESTERONE (P4)		CREAM

ESTROGEN/PROGESTERONE COMBINATION

<input checked="" type="checkbox"/>	BIOIDENTICAL	%				FORM
		E1	E2	E3	P4	
	ESTRADIOL (E2) WITH PROGESTERONE					CREAM
	ESTRIOL (E3) WITH PROGESTERONE					CREAM
	BIESTROGEN (E2E3) WITH PROGESTERONE					CREAM
	TRIOESTROGEN (E1E2E3) WITH PROGESTERONE					CREAM

TESTOSTERONE ONLY

<input checked="" type="checkbox"/>	BIOIDENTICAL	P4 %	FORM
	TESTOSTERONE		CREAM

Are all natural ingredients required? Yes _____ No _____
 Quantity: _____ # Of Refills: _____ Physician Specialty: _____
 SIG: _____
 Prescriber: _____
 NPI #: _____ DEA #: _____
 City: _____ State: _____ Zip: _____
 Office Phone: _____ Office Fax: _____
 Physicians Signature: _____

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