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

☑	BIOIDENTICAL	%			FORM
		E_1	E_2	E_3	
	ESTRADIOL (E_2)				CREAM
	ESTRIOL (E_3)				CREAM
	BI-ESTROGEN (E_2E_3): Common dosage: 20% Estradiol + 80% Estriol				CREAM
	TRI-ESTROGEN ($E_1E_2E_3$): Common dosage: 10% Estrone+10% Estradiol + 80% Estriol				CREAM

PROGESTERONE ONLY

☑	BIOIDENTICAL	P_4 %	FORM
	PROGESTERONE (P_4)		CREAM

ESTROGEN/PROGESTERONE COMBINATION

☑	BIOIDENTICAL	%				FORM
		E_1	E_2	E_3	P_4	
	ESTRADIOL (E_2) WITH PROGESTERONE					CREAM
	ESTRIOL (E_3) WITH PROGESTERONE					CREAM
	BIESTROGEN (E_2E_3) WITH PROGESTERONE					CREAM
	TRIESTROGEN ($E_1E_2E_3$) WITH PROGESTERONE					CREAM

TESTOSTERONE ONLY

☑	BIOIDENTICAL	P_4 %	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: _____