PRESCRIPTION

ANDROPAUSE ORDER FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME: DATE of BIRTH (Month / Day)

_____/_____

PRIMARY PHONE #: ◯ CELL ◯ HOME ◯ WORK SECONDARY PHONE #: ◯ CELL ◯ HOME ◯ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

DESCRIPTIONS

☐ Anastrazole Tablet (30)	1mg
☐ Clomiphene Tablet (30)	50mg
☐ HCG-Pregnyl	10,000 IU vial
☐ HCG-Novarel	5,000 IU vial
☐ HCG-Novarel	10,000 IU vial
☐ HCG-Generic Chorionic Gonadotropin	10,000 IU vial

THE FORMULATIONS BELOW REQUIRE WRITTEN PRESCRIPTION

☐ Testosterone Cream	_____mg/gm
☐ Testosterone SL Tab	◯ 25mg ◯ 50mg ◯ 100mg
☐ Testosterone Cypionate (10ml vial)	200mg/ml
☐ Testosterone Cypionate (1ml vial)	200mg/ml
☐ Testosterone Enanthate (5ml vial)	200mg/ml

Refills: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ PRN ◯ NR SIG:_____

WRITE PRESCRIPTION / ADDITIONAL COMMENTS

DOCTOR PHONE NPI # DEA #

OFFICE MANAGER PHONE OFFICE FAX OFFICE Email

SIGNATURE DATE (Month / Day / Year)

_____/_____/_____