PRESCRIPTION

FEMALE HORMONE REPLACEMENT 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:

SUPPOSITORIES

☐ Estradiol Vaginal Cream	0.01%-0.1% _____	Amount _____
☐ Estriol Vaginal Cream	0.01%-0.1% _____	Amount _____
☐ Estriol Vaginal Suppository	0.1mg-2mg _____	Amount _____
☐ Progesterone Vaginal Suppository	◯ 100mg ◯ 200mg	Amount _____

TOPICAL FORMULATIONS (Select 2 if needed)

☐ Biest / Triest (please indicate ratio of estrogens)	0.05mg-5mg _____	Amount _____
☐ DHEA	0.5mg-2.5mg _____	Amount _____
☐ Estriol	0.1mg-2mg _____	Amount _____
☐ Progesterone	10mg-200mg _____	Amount _____
☐ Testosterone (Must write this Rx)	0.1%-5% _____	Amount _____

ORAL MC CAPSULES

☐ Biest / Triest	0.1mg-5mg _____	Amount _____
☐ Cortisol MC	◯ 2.5mg ◯ 5mg ◯ 10mg	Amount _____
☐ DHEA	5mg-50mg _____	Amount _____
☐ Estriol	0.5mg-8mg _____	Amount _____
☐ Progesterone	25mg-400mg _____	Amount _____
☐ Serotonin	◯ 10mg ◯ 20mg ◯ 30mg ◯ 40mg	Amount _____
☐ T3 (Liothyronine) MC	All Strengths _____	Amount _____
☐ T3/T4 MC	All Strengths _____	Amount _____
☐ Testosterone (Must write this Rx)	0.5mg-5mg _____	Amount _____
☐ Thyroid USP Compounded	All Strengths _____	Amount _____
☐ Vitamin D3	50,000 IU	Amount _____

☐ **Check here to indicate combination compound**

SUBLINGUAL (RDTs, Troches, Tablet Triturates)

☐ Biest / Triest	0.625mg-5mg _____	Amount _____
☐ DHEA	_____	Amount _____
☐ Progesterone	25mg-200mg _____	Amount _____
☐ Testosterone (Must write this Rx)	0.25mg-3mg _____	Amount _____

☐ Custom Compound
Indicate Ingredients, strength, and form of medication requested

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) ____/____/____