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Bio-identical Hormone Replacement Therapy Prescription Form

PATIENT INFORMATION:

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Birth Date: _____

Allergies: _____ e-mail Address: _____

PHYSICIAN INFORMATION:

Physician Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ e-mail Address: _____

Hormones: (Circle your choice)

Estrogen	&/or	Progesterone	&/or	Testosterone
TriEst				
BiEst				
Estriol				

Dosage Forms: (Check your Choice)

<input type="checkbox"/> Slow Release Capsules	<input type="checkbox"/> Slow Release Capsules	<input type="checkbox"/> Slow Release Capsules
<input type="checkbox"/> Capsules	<input type="checkbox"/> Capsules	<input type="checkbox"/> Capsules
<input type="checkbox"/> Topical	<input type="checkbox"/> Topical	<input type="checkbox"/> Topical
<input type="checkbox"/> Troche	<input type="checkbox"/> Troche	<input type="checkbox"/> Troche
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Strength:* (Check your Choice)

<input type="checkbox"/> 0.625 mg	<input type="checkbox"/> 25 mg	<input type="checkbox"/> 0.5 mg
<input type="checkbox"/> 1.25 mg	<input type="checkbox"/> 50 mg	<input type="checkbox"/> 1.0 mg
<input type="checkbox"/> 2.5 mg	<input type="checkbox"/> 100 mg	<input type="checkbox"/> 1.5 mg
<input type="checkbox"/> 3.5 mg	<input type="checkbox"/> 150 mg	<input type="checkbox"/> 2.0 mg
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Quantity: _____

* Guidelines only– The dose should be according to the needs of your patient.

Check here if you want to combine these into a single dose form.

Directions:

REFILL _____ TIMES

D.E.A.: _____ Physician's Signature: _____