Compound Order Form - Thyroid

Patient Name_____ Date of Birth_____

Address_____ Phone_____

Allergies_____

☐ Liothyronine (T3) Capsules

IR or SR Capsules (circle one)

_____mcg
Sig: Take 1 capsule by mouth once daily
Qty #_____ Refills_____

☐ Levothyroxine (T4) Capsules

IR or SR Capsules (circle one)

_____mcg
Sig: Take 1 capsule by mouth once daily
Qty #_____ Refills_____

☐ Liothyronine (T3)_____mcg/Levothyroxine (T4)_____mcg

IR or SR Capsules (circle one)

Sig: Take 1 capsule by mouth once daily

Qty #_____ Refills_____

Physician Name_____ Date_____

Physician Signature/Person Authorizing and Title_____

Physician NPI or DEA#_____

Physician's Office Phone # _____