Hormone Compound Quick Order Form

Patient Full Name: _____ DOB: _____ Phone:_____

Patient Address: _____ City: _____ State: _____

·☐ Bi-Est (E3/E2)

Ratio: ·☐ 80/20 ·☐ 70/30 ·☐ 50/50 ·☐ Other:_____/_____

Dose: ·☐ 0.625mg ·☐ 1.25mg ·☐ 2.5mg ·☐ Other:_____mg

·☐ Progesterone:

·☐ 50mg ·☐ 100mg ·☐ 200mg ·☐ Other:_____mg

·☐ DHEA

·☐ 5mg ·☐ 10mg Other:_____mg

·☐ _____

·☐ _____mg

·☐ Estriol (not-Bi-est)

·☐ _____mg

·☐ Estradiol (not Bi-est)

·☐ _____mg

·☐ Enclomiphene Citrate

·☐ _____mg

Formulation:

·☐ Troche ·☐ Capsule ·☐ Cream (mg/mL) ·☐ Other:_____

If Capsule ·☐ IR (Immediate Release) or ·☐ SR (Sustained/Slow Release, i.e. E4M)

·☐ (Directions for use and please indicate a route, quantity, and frequency Ex: Apply 1mL topically qd):

_____

_____

Qty:_____ Refills: **1** **2** **3** **4** **5** **PRN** **NONE** (CIRCLE AUTHORIZED REFILLS)

Physician Name: _____ NPI or DEA: _____

Office Address:_____ Office Phone Number: _____

Signature: _____ Date:_____