Apothecary Options

Prescription Order Form

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Allergies: _____**Phone**: (_____) _____

COMPOUNDED MEDICATION

☐ Progesterone suppository ☐ 100mg ☐ 200mg

☐ Estradiol suppository 2mg

☐ Estradiol 2mg / Progesterone 100mg suppository

☐ Estradiol 2mg / Progesterone 200mg suppository

Quantity: _____ **Refills:** _____

Directions: _____

Prescriber Signature: _____ **Today Date:** _____

Prescriber Printed Name: _____ **□MD □DO □ND □PA □NP □CNM/CN**

State License: _____ **DEA:** _____ **NPI:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

3006 Esplanade, Suite I, Chico, CA 95973 * Phone: 530-345-RxRx (7979) * Fax: 530-345-9797
www.apothecaryoptions.com * **Email-** info@apothecaryoptions.com * **Find us on Facebook**