Compounded Prescription Order Form

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

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

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

COMPOUNDED MEDICATION

Compounded Estradiol 0.1mg/gm Vaginal Cream in HRT

(methyl & propyl-paraben-free, PPG-Free, Dye-free, GMO-free, Petrolatum-free, Fragrance-free, hypo-allergenic)

Cream Base

Sig: (check one)

- ❑ **Apply ½ gm with finger vaginally three times weekly.**
- ❑ **Insert ½ gm intravaginally three time weekly (w/ applicator).**
- ❑ **Apply ½ gm vaginally daily □ with applicator □ with finger (check one).**
- ❑ **Insert ½ gm intravaginally daily for 2 weeks then three time weekly thereafter.**
- ❑ **Other: _____**

Quantity: 30gm (EMP jar; approx. 3-4 month supply based on usage) Refills _____

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:** _____

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