Compounded *Prescription Order Form*

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

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

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

COMPOUNDED MEDICATION

Testosterone in HRT Cream Base

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

Dose: ❒ 12.5mg ❒ 25mg ❒ 50mg ❒ 100mg ❒ 200mg ❒ other:_____

(concentration of formula will be double the dose except for 200mg doses)
NOTE: MAXIMUM DAILY DOSE OF TESTOSTERONE IS 200MG.

Container Type: ❒ EMP jar (measured in gm) ❒ Pump (measured in ml)

Qty: (gm or ml depending on container) ❒ 45 ❒ 60 ❒ 90

Refill: _____ (Max 1 refill w/ a 90-day supply**. The dispensed quantity plus refills cannot exceed 6-month supply**)

Directions: Apply 1 pump (= to dose ordered above) topically to skin daily.
***We will call on all control prescriptions to validate legitimacy when faxed in.**

Enclomiphene Capsules

Dose: ❒ 12.5mg ❒ 25mg ❒ other:_____

Qty: ❒ 30 ❒ 90 ❒ other:_____

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:** _____

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