Date: ____________ Patient Name: ____
DOB: _____________**Address:** ____
City: ________**State:** ___ **Zip:** _______ **Phone:** ____________ **Allergies:**_________________
☐ **Call When Ready** ☐ **Text Message When Ready** ☐ **Delivery** ☐ **Mail Out**

☐ **Bi-Est (Cream OR Capsule)**
40/60; 50/50; 60/40; 70/30; 80/20
Strength:_______________ Qty:______________
Sig:____

☐ **Progesterone (Cream) 4%; 5%; 6%; 8%**
Strength:________________ Qty:_____________
Sig:____

☐ **Progesterone SR (Capsule) 25mg, 50mg, 75 mg, 100mg, 150mg, 200mg, 250mg, 300mg,**
Strength:_________________ Qty:_____________
Sig:____

☐ **Progesterone (Suppositories)**
25mg, 50mg, 100mg, 200mg, 400mg
Strength:__________ Qty:_________
Sig:____

☐ **Libido #1 Theophylline 2.6%/Arginine(L) 6%/Sildenafil 1% (Cream)** Qty: # 10 ml
Sig: Apply a pea-sized amount topically to clitoral area 5-30 min prior to intercourse as directed.

☐ **Libido #2 Theophylline 2.6%/Arginine(L) 6%/Menthol 0.025%/Nifedipine 0.2% (Cream)**
Qty: # 10 ml
Sig: Apply a pea-sized amount topically to clitoral area 5-30 min prior to intercourse as directed.

☐ **Boric Acid (Vaginal Capsule) 600 mg**
Strength:_______________ Qty:______________
Sig:____

☐ **Amour Thyroid (Tablet)**
Strength:_______________ Qty:______________
Sig:_______________________________________

☐ **Testosterone 1% (10 mg/ml) in Versabase Cream**
Qty: 9ml or _______
Sig: Apply 0.1ml (1mg) once daily in the AM for 2 weeks, then increase to 0.2ml (2mg) once daily for 2 weeks, then increase to 0.3ml (3mg) thereafter.

☐ **Testosterone 2% (20 mg/ml) in Versabase Cream**
Qty: 9ml o r_______
Sig: Apply 0.1ml (2mg) once daily in the AM as tolerated.

☐ **Testosterone 3% (30 mg/ml) in Versabase Cream**
Qty: 9ml o r_______
Sig: Apply 0.1ml (3 mg) once daily in the AM as tolerated.

☐ **Testosterone __________% in Versabase Cream**
Qty: 9ml o r_______
Sig: Apply _______________________________________
____
____

☐ **Testosterone 1% (Sublingual Drops)**
(0.1ml=1mg, 0.2ml=2mg 0.3ml=3mg)
Strength:________________ Qty:_____________
Sig: Apply 0.1ml SL once daily or _______________

☐ **Testosterone in Lipoderm Cream (Male BHRT)**
Strength:________________ Qty:_____________
Sig:____

☐ **Estriol 0.05% (0.5mg/gm) (Anhydrous Vaginal Gel)** Qty: 30 gm
Sig: Insert 1-3 gm vaginally HS for 7-10 days, then PRN to control symptoms (1-3 times weekly).

☐ **Estradiol 26mcg Vaginal Capsules**
Qty: 24 or _______
Sig: Insert 1 capsule vaginally twice a week

____ **Refills: 1 2 3 4 5 PRN**
Healthcare Provider Signature:
Print Name: ______________________________________ **Agent sending**: ______________________________
NPI: ____ **DEA**: _______________________________________

Clinic Name: ____
Clinic Address: ____
Clinic Phone/Fax: ____