Office Name:

Address:

City: **State:** **Zip:**

Phone:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: ____ /____ /_____ Phone: ( ) _____ - _____

Allergies: _____

New Patient: Fax current insurance information with R_x

Female Performance & BHRT

	Medications	Strength	Directions	Quantity (days)	Refills
BHRT	**Bi-Est** ☐ cream ☐ capsule ☐ troche ☐ 80/20 ☐ 70/30 ☐ 50/50 ☐ ___/___	☐ 0.5mg ☐ 0.625 ☐ 1mg ☐ 1.25mg ☐ 2mg ☐ 5mg ☐ 10mg ☐ ___ mg	☐ apply ___ gm qD ☐ 1 PO qD	☐ 30 ☐ 60 ☐_____	☐ ___ ☐ PRN ☐ none
	Tri-Est ☐ cream ☐ capsule ☐ troche ☐ 80/10/10 ☐ ___ /___ /___	☐ 0.5mg ☐ 0.625 ☐ 1mg ☐ 1.25mg ☐ 2mg ☐ 5mg ☐ 10mg ☐ ___ mg	☐ apply ___ gm qD ☐ 1 PO qD	☐ 30 ☐ 60 ☐_____	☐ ___ ☐ PRN ☐ none
	Progesterone ☐ cream ☐ capsule ☐ troche	☐ 25mg ☐ 50mg ☐ 75mg ☐ 100mg ☐ 200mg ☐ ___ mg	☐ apply ___ gm qD ☐ 1 PO qD	☐ 30 ☐ 60 ☐_____	☐ ___ ☐ PRN ☐ none
	_____ **(must write Testosterone)** ☐ cream ☐ capsule ☐ troche	☐ 1mg ☐ 2mg ☐ 4mg ☐ 5mg ☐ 10mg ☐ ___ mg	☐ apply ___ gm qD ☐ 1 PO qD	☐ 30 ☐ 60 ☐_____	☐ ___ ☐ none
	DHEA ☐ cream ☐ capsule ☐ troche	☐ 5mg ☐ 10mg ☐ 15mg ☐ 20mg ☐ ___ mg	☐ apply ___ gm qD ☐ 1 PO qD	☐ 30 ☐ 60 ☐_____	☐ ___ ☐ PRN ☐ none
	Pregnenolone ☐ capsule	☐ 25mg ☐ 50mg ☐ 100mg ☐ 250mg ☐ ___ mg	☐ ___ PO qD	☐ 30 ☐ 60 ☐_____	☐ ___ ☐ PRN ☐ none
	O **Estriol (E3)** O **Estradiol (E2)** O Estrone (E1) ☐ cream ☐ capsule ☐ troche ☐ vaginal cream	☐ 0.5mg ☐ 0.625 ☐ 1mg ☐ 1.25mg ☐ 2mg ☐ 5mg ☐ 10mg ☐ ___ mg	☐ apply ___ gm qD ☐ 1 PO qD ☐ PV 1gm qHS 14 days, PV gm qHS 2 times week for 14 days, PRN	☐ 30 ☐ 60 ☐___	☐ ___ ☐ PRN ☐ none
	CUSTOM:				
	Combination (1) cream / capsule	☐ YES ☐ NO	☐ apply ___ gm qD ☐ 1 PO qD	☐ 30 ☐ 60 ☐_____	☐ ___ ☐ PRN ☐ none

	Medications	Strength	Directions	Quantity	Refills
GHRH & Sexual Enhancement	**Sermorelin**	1000 mcg/ml ☐ 6 ml ☐ 12 ml	☐ INJ 0.3ml SQ QD Mon – Fri ☐ _____ (Dilute with 6ml sterile water)	☐ 1 ☐ 2 ☐ 3	☐ ___ ☐ PRN ☐ none
	Naltrexone LDN **(for migraines)**	☐ 1.5mg ☐ 3mg ☐ 4.5mg	Take 1 PO QHS	☐ 30 ☐ 60 ☐_____	☐ ___ ☐ PRN ☐ none
	Gabapentin **(for migraines)**	1.2%	Apply 1mL to wrist	☐ 30gm	☐ ___ ☐ PRN ☐ none
	Oxytocin (trochee)	☐ 10iu ☐ 50iu	Completely dissolve 1 trochee under tongue BID	60 - $45	☐ ___ ☐ PRN ☐ none
	Libido Cream **(must write Testosterone)**	Sildenafil 2.5%, Arginine 6%, Pentoxifylline 5% with ☐ _____ 0.4%	PRN PV prior to intercourse	15gm	☐ ___ ☐ PRN ☐ none

Additional Directions: _____

PCAB ACCREDITED Compounding Pharmacy

A4M American Academy of Anti-Aging Medicine

Compounding PHARMACY OF AMERICA

(office) 855-277-2488 (fax) 888-689-9892

Prescriber Name: _____

Prescriber Signature: _____

DEA# _____ **NPI#** _____

Date: ____ / ____ / _____

Supervising Physician: _____ **DEA#** _____

AM: Kristi Peterson