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

Urology – Male / Testosterone Replacement

	Condition	Medications / Concentration	Directions	Supply	Refills
Bladder	Cancer	Mitomycin C ☐ 40mg/40mL ☐ _____mg/mL	Use as directed for office administration ☐ _____	☐ 40mL ☐ _____	☐ ____ ☐ PRN
Bladder	Infection	Gentamicin 0.08mg/mL, Neomycin 0.5mg/mL, Polymyxin 100u/mL	Use as directed for office administration ☐ _____	☐ 40mL ☐ _____	☐ ____ ☐ PRN
Miscellaneous	Peyronie's	☐ Verapamil 50mg/mL (cream) ☐ Verapamil ____ mg/mL (cream)	Apply to affected area BID	60mL	☐ ____ ☐ PRN
Miscellaneous	Peyronie's	☐ Verapamil 50mg/mL, Dexamethasone 1mg/mL ☐ Verapamil ____mg/mL, Dexamethasone ____mg/mL	☐ 1 pump (1 gram) ☐ office administration	60mL	☐ ____ ☐ PRN
Miscellaneous	Peyronie's	Pentoxifylline 5% (cream)	Apply to affected area BID	60mL	☐ ____ ☐ PRN
Miscellaneous	Prostate Cancer (hot flashes)	Gabapentin 5% (transdermal gel)	Apply 1 gm to inner wrist as directed	60 grams	☐ ____ ☐ PRN

	Medication (must write Testosterone)	Concentration	Supplied	Directions	Refills
Testosterone Replacement Therapy	_____ Cypionate PLUS (sesame oil)	Cypionate 200mg/ml with Enanthate 20mg/ml	10ml ☐ include INJ kit	INJ ____ml ____ weekly	☐ ____ ☐ none
Testosterone Replacement Therapy	_____ Bi-blend (sesame oil)	Cypionate 180mg/ml Propionate 20mg/ml	10ml ☐ include INJ kit	INJ ____ml ____ weekly	☐ ____ ☐ none
Testosterone Replacement Therapy	_____ Cypionate (commercial)	200mg/ml	10ml ☐ include INJ kit	INJ ____ml ____ weekly	☐ ____ ☐ none
Testosterone Replacement Therapy	_____ Transdermal Gel	☐ 50mg ☐ 100mg ☐ 200mg	☐ 30gm ☐ 60gm ☐ 90gm	Apply _____ gm QD	☐ ____ ☐ none
Testosterone Replacement Therapy	Human Chorionic Gonadotropin (hCG) (commercial)	10,000iu (includes 10ml sterile water)	Lyophilized ☐ include INJ kit	Dilute with ____ ml sterile water INJ ___iu SQ ___QWK	☐ ____ ☐ PRN
Testosterone Replacement Therapy	Clomiphene Citrate (tablet)	50mg	30 tablets	Take 1 PO QD	☐ ____ ☐ PRN
Testosterone Replacement Therapy	Anastrozole (tablet)	1mg	30 tablets	☐ ½ ☐ 1 tablet PO ☐ 2 QWK ☐ 3 QWK ☐ daily	☐ ____ ☐ PRN
GHRH & Nandrolone	Medication (must write controlled)	Concentration	Supplied	Directions	Refills
GHRH & Nandrolone	Sermorelin	1000mcg/ml	12ml ☐ include INJ kit	☐ INJ 0.3ml SQ QD Mon - Fri	☐ ____ ☐ PRN
GHRH & Nandrolone	_____ Deconate	200mg/ml	10ml ☐ include INJ kit	INJ ___ml ___ weekly	☐ ____ ☐ none

Additional SIG:

ACCREDITED Compounding Pharmacy
Compounding PHARMACY OF AMERICA
(office) 855-277-2488 (fax) 888-689-9892

Prescriber Name: _____

Prescriber Signature: _____

DEA #: _____ **NPI #:** _____ **Date:** ___ /___ /_____

Supervising Physician: _____ **DEA #:** _____