HAIR GROWTH THERAPY

Clinic Name	
Address	
Phone	

Prescriber		NPI/DEA	

☐ New Patient (if new, please include address and phone number with DOB)
☐ Existing Patient (if existing, only DOB required unless information changed)

Patient Name		DOB	

Patient Address	
Patient Phone	

☐ Dye-free capsule (extra fee)

Allergy: _____

☐ Ship to Clinic	☐ Ship to Patient	☐ Patient Pick-up	☐ Bill Patient	☐ Bill Clinic

	Drug Name	Form	Strength
☐	*MINOXIDIL*	CAPSULE	0.75mg
☐	*MINOXIDIL*	CAPSULE	1.5mg
☐	*MINOXIDIL*	CAPSULE	1.75mg
☐	*MINOXIDIL/FINASTERIDE*	TOPICAL SOLUTION (mL)	6-0.1%
☐	*MINOXIDIL/FINASTERIDE*	TOPICAL SOLUTION (mL)	8-0.25%
☐	*MINOXIDIL/FINASTERIDE/LATANOPROST*	TOPICAL SOLUTION (mL)	6-0.1-0.01%
☐	*MINOXIDIL/TRETINOIN/FLUOCINOLONE*	TOPICAL SOLUTION (mL)	5-0.01-0.01%
☐	*MINOXIDIL/TRETINOIN/FLUOCINOLONE/ FINASTERIDE*	TOPICAL SOLUTION (mL)	5-0.01-0.01-0.25%
☐	*MINOXIDIL/TRETINOIN/PROGESTERONE/ FINASTERIDE*	TOPICAL SOLUTION (mL)	5-0.0025-0.25-0.1%
☐	*GHK-CU ACETATE*	TOPICAL SOLUTION (mL)	5mg/mL

Directions: _____Qty: _____ Refills:_____

Authorized Person: _____ Date: _____

Signature:_____

PRINT CLEAR FORM