HORMONE OPTIMIZATION

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	Strength	Drug Name	Strength
☐ *BIEST (ESTRIOL/ESTRADIOL) 80:20 CREAM, **30gm***	Select	☐ *BIEST (ESTRIOL/ESTRADIOL) 80:20 CAPSULE*	Select
☐ *BIEST (ESTRIOL/ESTRADIOL) 50:50 CREAM, **30gm***	Select	☐ *PROGESTERONE CAPSULE*	Select
☐ *BIEST 80:20-TESTOSTERONE CREAM, **30gm***	Select	☐ *ENCLOMIPHENE CAPSULE*	Select
☐ *PROGESTERONE CREAM, **30gm***	Select		
☐ *TESTOSTERONE CREAM, **30gm***	Select	☐ *PREGNENOLONE CAPSULE*	*30mg*
☐ *TESTOSTERONE TROCHE*	Select	☐ *DHEA CAPSULE*	*10mg*
☐ *DHEA CREAM, **30gm***	*25mg/gm*	☐ *TRIEST (ESTRIOL/ESTRADIOL/ESTRONE) 80:10:10 CAPSULE*	*2.5mg*
☐ *SERMORELIN NASAL SPRAY **6ML BOTTLE***	*1.5mg/mL*	☐ *TAMOXIFEN TABLET, COMM.*	*10mg*
☐ *ANASTROZOLE TABLET, COMM.*	*1mg*	☐ *TAMOXIFEN TABLET, COMM.*	*20mg*

PLEASE COMPLETE RED SECTION IF PRESCRIBING TESTOSTERONE:

ICD 10:_____ Day Supply: _____ Last office visit (Out-of-State only):_____

Directions: _____Qty: _____ Refills:_____

Authorized Person: _____ Date: _____

Signature:_____

PRINT **CLEAR FORM**