HORMONE OPTIMIZATION - INJECTABLES

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	
Patient Email	

Allergy: _____

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

Compound	Size
☐ ***GONADORELIN, 2mg/mL INJECTION,*** *4mL 4-VIAL PACK*	☐ ***TESTOSTERONE CYPIONATE IN GRAPESEED OIL,*** *50 mg/mL 5ML VIAL*
☐ ***LONG R3-IGF-1, 200mcg/mL INJECTION,*** *6mL 6-VIAL PACK*	☐ ***TESTOSTERONE CYPIONATE IN GRAPESEED OIL,*** *50 mg/mL 3ML VIAL*
☐ ***SERMORELIN, 2mg/mL INJECTION,*** *6mL 6-VIAL PACK*	☐ ***TESTOSTERONE CYPIONATE IN GRAPESEED OIL,*** *200 mg/mL 5ML VIAL*
	☐ ***TESTOSTERONE CYPIONATE IN GRAPESEED OIL,*** *200 mg/mL 3ML VIAL*

PLEASE COMPLETE RED SECTION IF PRESCRIBING TESTOSTERONE:

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

☐ Okay to compound in grapeseed oil for increased tolerance and less irritation/pain at injection site
☐ *Include syringes (extra fee)*

Directions: _____Qty: _____ Refills:_____

Authorized Person: _____Date: _____

Signature:_____

PRINT **CLEAR**