PATIENT INFORMATION

"Valid if transmitted by facsimile machine only"

PATIENT NAME: DATE OF BIRTH:

☐ Deliver to patient

ADDRESS: PHONE:

CITY: STATE: ZIP: ICD9 CODES/DX:

Insurance ID: Group: BIN: PCN:

Allergies:

MOST REQUESTED FORMULAS

☐	Anastrozole Capsule	☐ 0.25MG	☐ 0.5MG	☐ 1MG	☐ ____ MG
☐	Clomiphene Citrate Topical Gel	☐ 5%	☐ 7.5%	☐ 10%	☐ ____ %
☐	Clomiphene Citrate Capsule	☐ 10MG	☐ 25MG	☐ 50MG	☐ ____ MG
☐	Minoxidil 10%% - Finasteride 0.1% Topical Gel in VersaBase				
☐	Sildenafil AR Capsule	☐ 10MG	☐ 25MG	☐ 100MG	☐ ____ MG
☐	Sildenafil Troche	☐ 10MG	☐ 25MG	☐ 100MG	☐ ____ MG
☐	Tadalafil AR Capsule	☐ 3MG	☐ 7MG	☐ 22MG	☐ ____ MG
☐	Tamoxifen Capsule	☐ 1MG	☐ 5MG	☐ 10MG	☐ ____ MG
☐	Testosterone Topical Cream per ml	☐ 25MG	☐ 50MG	☐ 75MG	☐ ____ MG
☐	Testosterone Cypionate 200MG/ML INJ				

Quantity: ____ 30 Day Supply Other Quantity: ____

Sig: _____

Other Requested Formulations: _____

Refills 0 1 2 3 4 5 PRN

PRESCRIBER

Name: TEL:

SIGNATURE: _____ _____DATE___/___/_____

Dispense as Written May Substituted