

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ DOB: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Allergies: \_\_\_\_\_

✓	Mens BHRT	Strength	Quantity	Administration
	<b>Testosterone</b>			<input type="checkbox"/> Topical <input type="checkbox"/> Troche
	<b>Testosterone Cypionate</b> <i>*Compounded Sesame oil</i>	200mg/ml	10ml	<input type="checkbox"/> Injection
	<b>Testosterone Cypionate</b> <i>*Commercially Available</i>	200mg/ml	10ml	<input type="checkbox"/> Injection
	<b>Testosterone Enanthate</b>	200mg/ml	5ml	<input type="checkbox"/> Injection
	<b>Nandrolone Decanoate</b>	200mg/ml	10ml	<input type="checkbox"/> Injection <input type="checkbox"/> Cream
	<b>Aromatase Inhibitor Natural</b> <i>*Chrysin, Zinc, DIM, Indole 3 Carbinol</i>			<input type="checkbox"/> Capsule
	<b>Anastrozole Compounded</b>			<input type="checkbox"/> Capsule
	<b>Finasteride/Saw Palmetto</b> <i>*DHT Blocker</i>	1.5mg/320mg		<input type="checkbox"/> Capsule

Sig: \_\_\_\_\_

Refill:    0—1—2—3—6 Months—1 Year

M.D. Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DEA: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Ship To:**  
 Patient  
 Physician Office

**Bill To:**  
 Patient  
 Physician Office

