

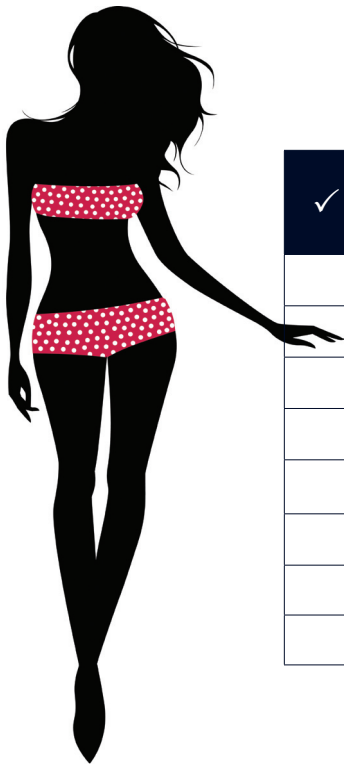
Patient Name: _____ Date: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ DOB: _____

Credit Card #: _____ Exp Date: _____

Allergies: _____



HCG WEIGHT LOSS THERAPY

✓ Men & Women HCG	Routes of Administration
HCG 4000 IU with Vitamin B12/B6	<input type="checkbox"/> Injection
HCG 5000 IU with Vitamin B12/B6	<input type="checkbox"/> Injection
HCG 10,000 IU with Vitamin B12/B6	<input type="checkbox"/> Injection
Novarel 10,000 IU	<input type="checkbox"/> Injection <i>commercial available</i>
Pregnyl 10,000 IU	<input type="checkbox"/> Injection <i>commercial available</i>
HCG 10,000 IU	<input type="checkbox"/> Injection <i>commercial available</i>
Syringes 31G 3/10cc	
Other:	

**Doctor Supervised Medical Program*

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

