AdvancedRx
Optimizing Provider Care™

WOMEN'S HEALTH RX SHEET

FAX TO: 615-866-6293

PATIENT INFO	PROVIDER INFO
Patient Name: _____	Provider Name: _____
Patient Phone #: _____	Practice Phone #: _____
Patient Address: _____	Practice Address: _____
City: _____ State: _____	City:_____ State: _____
Zip: _____ DOB: _____	Zip:_____ NPI#:_____
ALLERGIES* : _____	

BIO IDENTICAL HORMONE DROPS		SIG	REFILL
☐ Testosterone 50mg drops	☐30mL		☐ #____
☐ Progesterone 3gm drops	☐30mL		☐ #____
☐ Estradiol 150mg, Testosterone 50mg drops	☐30mL		☐ #____
☐ Estradiol 150mg, Testosterone 100mg drops	☐30mL		☐ #____
☐ Estradiol 50mg, Progesterone ***☐3mg OR ☐6mg*** , Testosterone 50mg drops	☐30mL		☐ #____
☐ Estradiol 75mg, Progesterone ***☐3mg OR ☐6mg*** , Testosterone 50mg drops	☐30mL		☐ #____
☐ Estradiol 150mg, Progesterone ***☐3mg OR ☐6mg*** , Testosterone 100mg drops	☐30mL		☐ #____
☐ Estradiol 150mg, Progesterone ***☐3mg OR ☐6mg*** , Testosterone 50mg drops	☐30mL		☐ #____
CREAMS AND GELS		**SIG**	**REFILL**
☐ Estradiol 0.01% with Vitamin E 200 IU/GM Cream	☐30g		☐ #____
☐ Estradiol 0.075% Gel	☐30g		☐ #____
☐ Estradiol 0.09% Cream	☐30g		☐ #____
☐ Estradiol 0.625% Cream	☐30g		☐ #____
☐ Testosterone Creams			
☐1% ☐2% ☐5% ☐10%	☐30g		☐ #____
☐ Testosterone Gels			
☐2% ☐5% ☐10%	☐30g		☐ #____
OTHER		**SIG**	**REFILL**
☐ Progesterone 100mg capsules	☐ #30		☐ #____
☐ Progesterone 200mg capsules	☐ #30		☐ #____
☐ Testosterone injections	☐___g		☐ #____
☐ Arimidex 1mg	# ____		☐ #____
☐ Clomid 50mg	# ____		☐ #____
☐ Vitamin D3 50,000 IU	#8		☐ #____
☐ *(please write in if not on form)*	# ____		☐ #____

Provider's Signature: _____ **Date:** _____