

Today's Date: \_\_\_\_\_

Fax Order To: \_\_\_\_\_

Date Needed: \_\_\_\_\_

# Sterile Prescription Order Form

**IMPORTANT: Compounded formulations are not available "For Office Use".**

- Compounded prescription orders must be patient-specific.
- To avoid delays in processing, you must complete the patient information section for each compounded prescription.

**PATIENT INFORMATION (REQUIRED):** Please fill in all fields to avoid delay in processing.

Patient Name: \_\_\_\_\_ Male / Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Street Address (No PO Boxes): \_\_\_\_\_

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

Phone (Home): \_\_\_\_\_ (W / Cell): \_\_\_\_\_ **Email:** \_\_\_\_\_

► **PURPOSE (Required for Testosterone):**  HRT  Menopausal Symptoms  Hypogonadism  Other (Please SPECIFY below)  
(Anabolic Steroids)

**ALLERGIES (Required):**  NKA  SPECIFY \_\_\_\_\_

► **GOV'T ISSUED ID REQUIRED TO PROCESS TESTOSTERONE ORDERS:**

(Drivers License, State Issued ID, Passport or Military ID)

## PRESCRIPTION:

Drug \_\_\_\_\_ Strength \_\_\_\_\_ Vial Size \_\_\_\_\_ Quantity \_\_\_\_\_

Directions (please include dose and frequency) \_\_\_\_\_ Preserved or Pres-Free\* \_\_\_\_\_ Refills \_\_\_\_\_

Circle Appropriate Route of Administration(s): IV IM SQ ID (Intradermal- Antigens/Mesotherapy) Prolotherapy

**PRACTITIONER INFORMATION:** Circle Designation: MD MB DO PA NP ND DDS DVM DPM

Practitioner Name (Please Print) \_\_\_\_\_ ► **SIGNATURE (REQUIRED)** ◀ \_\_\_\_\_

DEA # \_\_\_\_\_ License # \_\_\_\_\_

Office Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Contact / Faxed By \_\_\_\_\_

Place Office Address Stamp Here.  
**(Signature Still REQUIRED.)**

*(Georgia Requires Prior Patient Authorization to Ship Prescriptions to Practitioners.)*

## SHIPPING INFORMATION:

**Shipping (Please Circle Options):** → Ship to Practitioner / Ship to Patient

## BILLING INFORMATION:

**Billing (Please Circle Options):** → Bill Practitioner / Bill Patient

Name on Card: \_\_\_\_\_

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

New Credit Card # (M/C, Visa, AMX, Discover): \_\_\_\_\_ Exp. Date **(Required):** \_\_\_\_\_

Last 4 #'s of Credit Card **On File (Required):** \_\_\_\_\_ Exp. Date **(Required):** \_\_\_\_\_

► **\*\*\*Please note that when using a credit card on file, it is necessary to provide us with the last 4 digits & the expiration date of that card EVERY time an order is placed\*\*\***