BHRT ORDER FORM

Patient Information

NAME	DOB
ADDRESS	
CITY	STATE/ZIP
PHONE	EMAIL
ALLERGIES	SEX

Select Medication

☐ **BHRT TOPICAL: Cream *or* Troche (circle one)** Quantity: 30 Refills: _____

☐ Bi-Est 80:20 OR ☐ Bi-Est 50:50
☐ Estradiol OR ☐ Estriol
☐ Progesterone (micronized)
☐ Testosterone (micronized)
☐ DHEA

_____mg/mL
_____mg/mL
_____mg/mL
_____mg/mL
_____mg/mL

$55

Instructions:
☐ Dissolve one troche between cheek and gum once daily ☐ Apply 1 gram (four clicks) of cream to skin once a day

☐ **CAPSULES (*Any* Combination of Ingredients)**

☐ Testosterone capsules _____ mg (mg: 1 mg, 2 mg, 3 mg, 4 mg, 5 mg, other)
☐ Progesterone SR capsules _____ mg (mg: 10, 25, 50, 75, 100, 125, 150, 175, 200, 225, 250, 275, 300)
☐ Estradiol_____ mg ☐ Estriol _____mg ☐ DHEA_____mg

Instructions: ☐ Take 1 capsule by mouth once daily Quantity:_____ Refills: _____

$48 for 30 caps | $90 for 60 caps | $130 for 90 caps

Sig: _____ QTY: _____ capsules

☐ **Testosterone Cypionate 200 mg/mL IM inj:** $20 for 1 mL or $60 for 10 mL

Sig: _____

Quantity: _____ Refills: _____

Prescriber Information

PROVIDER NAME:	
DEA #:	PHONE #:
PROVIDER SIGNATURE:	DATE:

Robins Pharmacy

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