

Date: _____

MEDICATION ORDER

Practice Name: _____

Patient _____

Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Home PH: _____ Work PH: _____ Cell PH: _____

E-Mail: _____

Pharmacy Insurance Co.: _____

DATE: _____

Group ID: _____ Policy #: _____

DOB _____/_____/_____

Primary Nurse: _____

_____**Bravelle** 75 IU # _____
_____**IM** _____**SQ** # _____refills

_____**Follistim AQ** 75 IU # _____
150 IU # _____ 300 IU # _____
600 IU # _____ 900 IU # _____
_____refills

_____**Gonal-F RFF** 75 IU # _____
_____refills

_____**Gonal-F MULTI-DOSE**
450 IU # _____ 1050IU # _____
_____refills

_____**Gonal-f RFF PEN**
300 IU # _____ 450 IU # _____
900 IU # _____ # _____refills

_____**Luveris 75 IU** # _____vials
_____refills

_____**Menopur 75 IU** # _____vials
_____refills

_____**Repronex 75 IU** # _____vials
_____refills

_____**HCG/Lowdose**
Sig: _____

_____**Novarel/ HCG** 10,000 IU #1
_____**SQ** _____**IM** # _____refills

_____**Ovidrel 250mcg** # _____
_____refills

_____**Cetrotide** .25mg _____ 3mg _____
_____ # _____refills

_____**Ganirelix** # _____ # _____refills

_____**Leuprolide 2 week kit** #1
_____refills

_____**Microdose Lupron** (0.2cc=50mcg)
Sig: 50 mcg SQ BID # _____refills

_____**Crinone 8%** # _____applicators
_____refills

_____**Endometrin 100mg**
Box of 21 tabs # _____boxes
_____refills Sig: _____

_____**Progesterone in sesame oil**
50 mg.cc / 10 ml vial # _____ # _____refills

_____**Prometrium** 200 mg # _____
Sig: 1 Vaginally BID # _____refills

_____**Delestrogen** 20 mg/ml 5cc
_____refills

_____**Estradiol** _____#
_____**1.0 mg tab** _____**2.0 mg tab**
_____refills

_____**Clomiphene** 50 mg # _____
Sig: _____
_____refills

_____**Doxycycline** 100 mg tab #28
Sig: 1 PO Bid x 7 days for pt and spouse. # _____refills

_____**Zithromax** 500mg # _____
_____refills

_____**Ortho-Novum** _____ 1/35 _____ 1/50
1 # _____refills

_____**Prenatal Vitamins** # _____
_____refills

_____**1/2cc Insulin Syringes** # _____
Microfine Needles

_____**1 cc/ ml Syringes**
with 27 G 1/2" Needles # _____
_____ 22 G 1 1/2" Needles

_____**3 ml Syringes Luerlock 22 G 1 1/2"**
_____ 27G 1/2" Needles
_____ 18 G 1 1/2" Needles

_____**Other** _____
Sig: _____
_____refills

_____**Other** _____
Sig: _____
_____refills

_____**Other** _____
Sig: _____
_____refills

_____**Sharps Container**

*Interchange is mandated unless practitioner writes the words "Brand Necessary"

Physicians Signature: _____

Anticipated Start Date: _____

_____, M.D.