



BHRT Prescription Order Form

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Allergies: _____ Phone: (____) _____

COMPOUNDED MEDICATION

✓ Provider requesting the formula to be compounded in HRT cream Base

☐ Bi-Est (E2/E3): ☐ 20/80% ☐ 50/50% _____ mg/DOSE (Range: 0.2mg – 1mg per DAY)

☐ Estradiol (E2): _____ mg/DOSE (Range: 0.025–0.5mg per DAY)(Usual 0.05mg/DOSE)

☐ Estriol (E3): _____ mg/DOSE (Range: 0.25-2mg per DAY)

☐ Progesterone: _____ mg/DOSE (Range:10-50 mg per dose)

☐ Testosterone: _____ mg/DOSE (Range:0.25–2mg per day (max 90-day supply Plus 1 refill (total 180 day supply allowed by law))

☐ DHEA: _____ mg/DOSE (Range: 0.5–5mg per day)

☐ Check this box if you want us to combine all the hormones into one formula. Some limitations apply.

1. **Directions:** _____

(Application per dose usually equals 0.5-1gm depending on drug concentration and application site, we usually make the concentration double the dose to achieve the amount applied)

2. **Form:** Cream

3. **Route:** ☐ topically ☐ vaginally (w/finger) ☐ Intravaginally (w/applicator) ☐ _____

4. **Frequency:** ☐ daily ☐ three times weekly ☐ Other: _____

5. **Container:** ☐ EMP jar ☐ Pump (note:1 pump = 0.5ml) ☐ Clicker (note:20 clicks = 1ml)

Quantity: ☐ 30gm ☐ 45gm ☐ 60gm ☐ Other: _____ **Refills:** _____

Prescriber Signature: _____ Today Date: _____

Prescriber Printed Name: _____ ☐ MD ☐ DO ☐ ND ☐ PA ☐ NP ☐ CNM/CN

State License: _____ DEA: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____