



<b>Patient's Name:</b>	<b>Prescriber's Name:</b>
Street Address:	Street Address:
City, State ZIP:	City, State ZIP:
Date of Birth:	Office #:
Phone (CELL)#:	Fax #:
Email:	Email:
Patient Allergies:	

**PRESCRIBER'S SIGNATURE: X** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Commonly Requested Compounds for Men's Health**

1. \_\_\_\_\_ **Testosterone 100mg/ml Topical Cream**  
 0.25ml=1 Click (25mg)     0.5ml=2 Clicks (50mg)     0.75ml=3 Clicks (75mg)     1ml=4 Clicks (100mg)

SIG: \_\_\_\_\_

2. \_\_\_\_\_ **Testosterone 25mg Base A Troche**

SIG: \_\_\_\_\_

3. \_\_\_\_\_ **Sildenafil 20 mg T.T. (200 mg mold) Polyglycol Troche Base**

SIG: \_\_\_\_\_

4. \_\_\_\_\_ **Anastrozole 1mg/ml - Testosterone Cypionate 200mg/ml Oil Injection Solution**

SIG: \_\_\_\_\_

5. \_\_\_\_\_ **Clomiphene Citrate 5% (W/V) Topical Gel**

SIG: \_\_\_\_\_

6. \_\_\_\_\_ **Chorionic Gonadotropin 1000 U/ml Injection Solution**

SIG: \_\_\_\_\_

7. \_\_\_\_\_ **Minoxidil 10%% - Finasteride 0.1% Topical Gel in VersaBase**

SIG: \_\_\_\_\_

8. \_\_\_\_\_ **Minoxidil 5% - Tretinoin 0.025% - Finasteride 0.05% Topical Solution**

SIG: \_\_\_\_\_

**Refills: (Number of refills indicated here refers to all medications prescribed above)**

\_\_\_\_\_ 5    \_\_\_\_\_ 4    \_\_\_\_\_ 3    \_\_\_\_\_ 2    \_\_\_\_\_ 1