GATEWAY MEDICAL PHARMACY

Phone: (503) 254-7383 • Fax: (503) 254-4568

HORMONE COMPOUND ORDER FORM

Patient Information

Name:_____ DOB:_____ Phone:_____

Address:_____ Allergies:_____

Please select which ingredients, and specify which strength, you would like to prescribe:

◯ Bi-Est:

E3/E2 Ratio: ◯ 80/20 ◯70/30 ◯50/50 ◯ Other _____ /_____

Dose: ◯ 0.625mg ◯ 1.25mg ◯2.5mg ◯ Other _____mg

◯ Progesterone:

Dose: ◯ 50mg ◯ 100mg ◯ 200mg ◯ Other _____mg

◯ DHEA:

Dose: ◯ 5mg ◯10mg ◯ Other _____mg

◯ Testosterone (**Provide DEA # below**):

Dose: ◯ 1mg ◯2mg ◯4mg ◯ Other _____mg

◯ Estriol (not Bi-Est)

Dose: ◯ _____mg

◯ Estradiol (not Bi-Est)

Dose: ◯ _____mg

Formulation: ◯ Troche ◯ Capsule ◯ Cream(mg/ml) ◯ Other_____

◯ T3/T4 CAPSULES:

Formulation: ◯ SR ◯ IR

Dose: ◯T3_____mg ◯T4_____mg

Directions for use (please include a route, quantity, and frequency EX: Apply 1mL topically daily):

_____

Prescriber Printed Name: _____ Phone: _____

Prescriber Signature:_____Date _____

Prescriber DEA # _____ NPI# _____

Clinic Name and Address: _____