

Office Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____ - _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: ____ / ____ / ____ Phone: () _____ - _____

Allergies: _____

New Patient: Fax current insurance information with Rx

MALE UROLOGY

Pellets	Medication: Concentration: Quantity (must write Testosterone)		
	<input type="checkbox"/> _____ : _____ mg: _____	<input type="checkbox"/> _____ / Anastrozole: _____ mg / _____ mg : _____	
	Directions	To be implanted in medical office	Refills <input type="checkbox"/> _____ <input type="checkbox"/> none
	Date Needed (Appointment Date): ____ / ____ / ____ * Please allow 72 hours lead time on Pellet orders *		Trocar Kit : <input type="checkbox"/> 3mm: _____ <input type="checkbox"/> 4.5mm: _____
			3mm: ≤ 100mg 4.5mm: = 200mg

Testosterone Replacement Therapy	Medications (must write Testosterone)	Concentration	Supplied	Directions	Refills
	_____ Plus - Cypionate 200mg/ml	(Sesame Oil) with Enanthate 20mg/ml	<input type="checkbox"/> 10ml	INJ _____ ml _____ weekly <input type="checkbox"/> include kit	<input type="checkbox"/> _____ <input type="checkbox"/> none
	_____ Transdermal Gel	<input type="checkbox"/> 100 mg/mL <input type="checkbox"/> 200mg/mL	<input type="checkbox"/> 30 day <input type="checkbox"/> 60 day <input type="checkbox"/> 90 day	Apply _____ gm QD	<input type="checkbox"/> _____ <input type="checkbox"/> none
	Human Chorionic Gonadotropin (hCG) with Methylcobalamin	<input type="checkbox"/> 1000iu/100mcg /ml <input type="checkbox"/> 5000iu/500mcg/ml	QTY <input type="checkbox"/> 5 ml <input type="checkbox"/> 10 ml	INJ _____ iu SQ _____ weekly <input type="checkbox"/> include injection kit	<input type="checkbox"/> _____ <input type="checkbox"/> PRN
	Clomiphene Citrate (tablet)	50mg	30 tablets	take 1 PO QD	<input type="checkbox"/> _____ <input type="checkbox"/> PRN
Anastrozole (tablet)	1mg	30 tablets	<input type="checkbox"/> ¼ <input type="checkbox"/> ½ <input type="checkbox"/> 1 tablet PO <input type="checkbox"/> 2 QWK <input type="checkbox"/> 3 QWK <input type="checkbox"/> daily	<input type="checkbox"/> _____ <input type="checkbox"/> PRN	

Bi-Mix & Tri-Mix	Papaverine	Phentolamine	Alprostadil (PGE)	Refills	Quantity
	<input type="checkbox"/> 15 mg/ml	<input type="checkbox"/> 0.5 mg/ml	<input type="checkbox"/> 5 mcg/ml	<input type="checkbox"/> 1 <input type="checkbox"/> PRN <input type="checkbox"/> none	<input type="checkbox"/> 5ml: _____ <input type="checkbox"/> 10ml: _____
	<input type="checkbox"/> 30 mg/ml	<input type="checkbox"/> 1 mg/ml	<input type="checkbox"/> 10 mcg/ml	<input type="checkbox"/> 1 <input type="checkbox"/> PRN <input type="checkbox"/> none	<input type="checkbox"/> 5ml: _____ <input type="checkbox"/> 10ml: _____
	<input type="checkbox"/> 60 mg/ml	<input type="checkbox"/> 4 mg/ml	<input type="checkbox"/> 50 mcg/ml	<input type="checkbox"/> 1 <input type="checkbox"/> PRN <input type="checkbox"/> none	<input type="checkbox"/> 5ml: _____ <input type="checkbox"/> 10ml: _____
	<input type="checkbox"/> Custom:				
Directions					

Sexual Performance	Medication	Strength / Flavor	Supplied	Quantity	Refills
	Sildenafil with Apomorphine 2mg	<input type="checkbox"/> 25mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg	<input type="checkbox"/> Troches <input type="checkbox"/> Dye-free Capsule	<input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> _____ <input type="checkbox"/> PRN <input type="checkbox"/> none
	Vardenafil with Apomorphine 2mg	<input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg	<input type="checkbox"/> Troches <input type="checkbox"/> Dye-free Capsule	<input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> _____ <input type="checkbox"/> PRN <input type="checkbox"/> none
	Avanafil with Apomorphine 2mg	<input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg	<input type="checkbox"/> Troches <input type="checkbox"/> Dye-free Capsule	<input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> _____ <input type="checkbox"/> PRN <input type="checkbox"/> none
	Directions	<input type="checkbox"/> Troche: completely dissolve <input type="checkbox"/> ¼ <input type="checkbox"/> ½ <input type="checkbox"/> 1 troche under tongue 30 minutes prior to sexual activity <input type="checkbox"/> Capsule: take 1 capsule by mouth 30 minutes prior to sexual activity			
Sexual Performance	Medication	Strength / Flavor	Supplied	Quantity	Refills
	Tadalafil with Apomorphine 2mg	<input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg	<input type="checkbox"/> Troches <input type="checkbox"/> Dye-free Capsule	<input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> _____ <input type="checkbox"/> PRN <input type="checkbox"/> none
	Directions	<input type="checkbox"/> Troche: completely dissolve <input type="checkbox"/> ¼ <input type="checkbox"/> ½ <input type="checkbox"/> 1 troche under tongue <input type="checkbox"/> once daily <input type="checkbox"/> 1-2 hours prior to sexual activity <input type="checkbox"/> Capsule: take 1 capsule by mouth <input type="checkbox"/> once daily <input type="checkbox"/> 1-2 hours prior to sexual activity			

Additional Directions: _____



(office) 855-277-2488 (fax) 888-689-9892

Physician Name: _____

Physician Signature: _____

DEA# _____ NPI# _____

Date: ____ / ____ / ____