TOPICAL ANDROGENIC HORMONES

Prescriber:		Patient:	DOB:
Address:		Phone:	Sex:
		Address:	
City:	State: Zip:		
Phone:	Fax:	City:	State: Zip:
DEA:	NPI:	Email:	
Allergies:			

HORMONAL WELLNESS | TOPICAL ANDROGENIC HORMONES

USE THE SPACE BELOW TO WRITE IN THE CONTROLLED SUBSTANCE:

_____ **TOPICAL CREAM**

WOMEN'S STRENGTHS

ALL CONCENTRATIONS EXPRESSED BELOW ARE IN MG/GM

STRENGTH:	☐ **1 MG**	☐ **2 MG**	☐ **3 MG**	☐ **4 MG**	☐ **5 MG**
	☐ **10 MG**	☐ **20 MG**	☐ **30 MG**	☐ **40 MG**	☐ **50 MG**

REFILLS

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

MEN'S STRENGTHS

ALL CONCENTRATIONS EXPRESSED BELOW ARE IN MG/GM

STRENGTH:	☐ **75 MG**	☐ **100 MG**	☐ **150 MG**	☐ **175 MG**	☐ **200 MG**

QUANTITY

☐ **30 GM** ☐ **90 GM** **OTHER:** _____ **GM**

☐ **CUSTOM STRENGTH:** _____ **MG/GM**

INSTRUCTIONS:	**APPLY**_____ **MG TOPICALLY:**	☐ **EVERY DAY**	☐ **TWICE DAILY**	**ALTERNATIVE FREQUENCY:**

Comments:

PRESCRIBER:

Signature: _____ Date: ☐☐☐