WOMEN'S SEXUAL WELLNESS

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

HORMONES | WOMEN'S SEXUAL WELLNESS

HORMONE	STRENGTH	QUANTITY	DELIVERY SYSTEM
☐ PROGESTERONE	_____ MG	☐ 30	☐ TOPICAL (MG/GM)
☐ DHEA	_____ MG	☐ 60	
☐ ESTRIOL (E3)	_____ MG	☐ 90	☐ VAGINAL (MG/GM)
☐ ESTRADIOL (E2)	_____ MG	☐ 180	
☐ ESTRONE (E1)	_____ MG	OTHER: _____	☐ TROCHE (MG)

REFILLS

0 ○ 1 ○ 2 ○
3 ○ 4 ○ 5 ○
6 ○ 7 ○ 8 ○
9 ○ 10 ○ 11 ○

USE THE SPACE BELOW TO WRITE IN THE CONTROLLED SUBSTANCE:

DRUG: _____ **STRENGTH:** _____ **MG/GM -OR-** _____ **MG/TROCHE**

TOPCAL SIG: **APPLY** _____ **(AMOUNT)** **ML TOPICALLY TO** _____ **(LOCATION)** _____ **(FREQUENCY)**

TROCHE SIG: **DISSOLVE 1 TROCHE IN CHEEK AREA OF MOUTH** _____ **(FREQUENCY)**

PRESCRIBER:

Signature: _____ Date: ☐☐☐