WOMEN'S HEALTH REFERRAL FORM

DATE:___________________________ SHIP TO:
DATE NEEDED: ___________________ ☐ PATIENT ☐ OFFICE

PATIENT INFO

NAME: ______________________ E-MAIL______________________ DOB:______________ ☐ MALE ☐ FEMALE

ADDRESS: ______________________ CITY______________________ STATE________ ZIP____________

HOME TELEPHONE:______________________ MOBILE PHONE:______________________ SS#__ __ __ - __ __ - __ __ __ __

INSURANCE INFO: *PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)*

CLINICAL INFORMATION

Diagnosis

☐ ________________ (diag. code: __________)
☐ ________________ (diag. code: __________)
☐ ________________ (diag. code: __________)
• Date of diagnosis: ___________

Other Information

Allergies ______________________
Other Medications ______________________
____

PRESCRIPTION INFORMATION

Progesterone Topicals and Orals	Quantity	Refills
☐ **Progesterone Cream** | Strength(per gm): ☐ 25mg ☐ 50mg ☐ 100mg ☐ 150mg ☐ 200mg ☐ ______mg Sig: Apply 1ml topically ☐ QAM ☐ QHS ☐ BID ☐ Other:______________________	☐ 30g ☐ 60g ☐ _______	_______
☐ **Progesterone SR Caps** | Strength: ☐ 25mg ☐50mg ☐100mg ☐150mg ☐200mg ☐______mg Sig: Take 1 capsule by mouth ☐ QHS ☐ BID ☐ Other:______________________	☐ 30 ☐ 60 ☐ _______	_______

Estrogen Topical and Orals	Quantity	Refills
☐ **Estradiol (E2) Cream** | Strength(per gm): ☐ 0.5mg ☐ 1mg ☐ 1.5mg ☐ 2mg ☐_______mg Sig: Apply 1ml topically ☐ QAM ☐ QHS ☐ BID ☐ Other:______________________	☐ 30g ☐ 60g ☐ _______	_______
☐ **Bi-est Cream** (Estriol/Estradiol) | Strength(per gm): ☐ 0.5mg ☐ 1mg ☐ 1.5mg ☐ 2mg ☐______mg Sig: Apply 1ml topically ☐ QAM ☐ QHS ☐ BID ☐ Other:______________ | ☐50:50 ☐ 70:30 ☐80:20 ☐_____	☐ 30g ☐ 60g ☐ _______	_______
☐ **Bi-est SL Tablets** (Estriol/Estradiol) | Strength: ☐ 0.5mg ☐ 1mg ☐ 1.5mg ☐ 2mg ☐______mg Sig: Dissolve 1 tablet SL ☐ QAM ☐ BID ☐ Other:______________________ | ☐50:50 ☐ 70:30 ☐80:20 ☐_____	☐ 30 ☐ 60 ☐ _______	_______
☐ **Tri-est Cream** (Estriol/Estradiol/Estrone) | Strength(per gm): ☐ 0.5mg ☐ 1mg ☐ 1.5mg ☐ 2mg ☐______mg Sig: Apply 1ml topically ☐ QAM ☐ QHS ☐ BID ☐ Other:______________ | ☐30:50:20 ☐80:10:10 ☐_______	☐ 30g ☐ 60g ☐ _______	_______
☐ **Estriol Capsules** | Strength: ☐ 1mg ☐ 2mg ☐ 8mg ☐______mg | ☐ SR ☐ IR Sig: Take 1 capsule by mouth ☐ QAM ☐ BID ☐ Other:______________________	☐ 30 ☐ 60 ☐ _______	_______

Testosterone Topicals and Orals **Testosterone must be hand written**	Quantity	Refills
☐ _______________**Cream** | Strength(per gm): ☐ 2mg (0.2%) ☐ 10mg (1%) ☐ 20mg (2%) ☐_______mg Sig: ☐ Apply 0.5-1ml topically daily ☐ Other:______________________	☐ 30g ☐ 60g ☐ _______	_______
☐ _______________ **Capsules/Tablets** | Strength: ☐ 2.5mg ☐ 5mg ☐ 10mg ☐______mg | ☐ SR ☐ IR ☐ SL Sig: Take 1 cap/tab by mouth ☐ QAM ☐ BID ☐ Other:______________________	☐ 30 ☐ 60 ☐ _______	_______

Other	Quantity	Refills
☐ **DHEA Capsules** | Strength: ☐ 5mg ☐ 10mg ☐ 20mg ☐______mg | ☐ SR ☐ IR Sig: Take 1 capsule by mouth ☐ QAM ☐ BID ☐ Other:______________________	☐ 30 ☐ 60 ☐ _______	_______
☐ **[☐ Estriol -OR- ☐ Estradiol] VAGINAL [☐ Cream -OR- ☐ Suppositories]** Strength (per gm/Ea): ☐ 0.125mg ☐ 0.5mg ☐ 1mg ☐ 1.5mg ☐______mg Sig: Insert 1gm/supp vaginally HS for 1 wk then 2-3x wkly PRN vaginal dryness	☐ 15 ☐ 30 g or ea ☐ _______	_______
☐ **Arginine 6%/Aminophylline 3%/Menthol 0.1% Cream** | Add: ☐ Sildenafil 1% ☐ ______________ Sig: Apply pea size amount clitorally 30 minutes prior to sexual activity for libido *(Write in: Testosterone 2%)*	☐ 15g ☐ 30g ☐ _______	_______
☐ **Boric Acid 600mg Suppositories** Sig: Insert 1 supp vaginally HS for 2 wk then 1 weekly PRN for Vaginitis	☐ 30 ☐ 60 ☐ _______	_______
☐ **Other:**		_______

PRESCRIBER INFORMATION

Prescriber's Name: ______________________ Contact Person:______________________

Telephone: ______________________ Fax:______________________ Email:______________________

Office Address: ______________________ City:______________ State: ______ Zip:________

NPI # : ______________ DEA # : ______________ UPIN # : ______________ Medicaid Provider # :______________

______________________ ___________ *______________________

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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