BH-Compounding Order Form

Valid only if transmitted by facsimile machine

PATIENT INFORMATION

Patient Name _____ Phone _____ DOB ____/____/____ SSN ____ - ____ - ____

Address _____ City _____ State _____ Zip _____

ICD10 CODES/DX _____ ☐ Patient will pick up at pharmacy ☐ Patient requests delivery Known Allergies _____

BORIC ACID

☐ 200mg ☐ 400mg ☐ 600mg

BI-EST (80% Estriol/20% Estradiol

☐ 0.05mg ☐ 0.1mg ☐ 0.02mg ☐ 0.5mg
☐ 0.625mg ☐ 1.25mg ☐ 2.5mg ☐ other _____

BI-EST (50/50 Estriol/Estradiol

☐ 0.05mg ☐ 0.1mg ☐ 0.02mg ☐ 0.5mg
☐ 0.625mg ☐ 1.25mg ☐ 2.5mg ☐ other _____

ESTRADIOL

☐ 0.5mg ☐ 1mg ☐ 1.25mg ☐ 1.5mg ☐ other _____

PROGESTERONE

☐ 6.25mg ☐ 12.5mg ☐ 25mg ☐ 75mg
☐ 100mg ☐ 150mg ☐ 200mg ☐ other _____

☐ 0.5mg ☐ 1mg ☐ 1.25mg ☐ 1.5mg ☐ 2mg
☐ 2.5mg ☐ 3mg ☐ 4mg ☐ 5mg ☐ other _____

DREAM CREAM

☐ L-Arginine 6%, Aminophyline 3% ☐ 30gm ☐ other_____
Sig: Apply 15-30 minutes before intercourse.

☐ Sildenafil 2%, Aminophylline 3%, Arginine HCl 6% ☐ 30gm ☐ other_____
Sig: Apply 15-30 minutes before intercourse.

E2E3 VAGINAL CREAM

☐ Estradiol 0.01%, Estriol 0.05% ☐ 20gm ☐ other_____
Sig: Insert 1gm vaginally every evening at bedtime for 2 weeks, then 1-3 times a week as needed.

☐ Vitamin E 200 u/gm Vaginal Cream ☐ 30gm ☐ other_____
Sig: Insert 1gm vaginally every day.

EXTERNAL HEMORRHOIDS

☐ Lidocaine 5%, Hydrocortisone 1.25%, Diltiazem 2% Cr: (Dispensed in tube) Additions_____ (LHD)
Sig: Apply 1gm (1/4 teaspoon = 1 gm) to affected area 2-3 times daily. FOR EXTERNAL USE ONLY QTY: 30gm (14 - day supply)

ADRENAL HEALTH

☐ #60
Sig: Take 2 capsules daily.

ALL PURPOSE NIPPLE OINTMENT

☐ Mupirocin 1%, Betamethasone Acetate 0.025%, Clotrimazole 2% ☐ 30gm ☐ other_____
Sig: Apply sparingly after each feeding. (Sparingly means just enough to make nipples and areola glossy or shinny.)

QUANTITY

_____ 120gm Other Quantity _____ Refills 0 1 2 3 4 5 PRN ☐

DOSAGE FORMS

☐ CREAM ☐ SUPPOSITORY
☐ CAPSULE ☐ SUBLINGUAL
☐ TROCHE
☐ OTHER
_____

SIG

☐ QD ☐ QAM ☐ QPM
☐ BID ☐ TID ☐ QHS
☐ QS 1 Month

OTHER PRESCRIPTION

PRESCRIBER

Physician Name _____ Phone _____

Signature _____ _____ Date ____/____/____

Dispense as Written May Substitute

"The information provided herein is for reference only and is not to be relied upon as making any representation as to the efficacy of any particular formulations. The sample formulations described herein result from prescriptions previously ordered by professionals licensed to write prescriptions in their respective discipline. Nothing herein is intended to replace or influence the independent judgment of any licensed professional."**The information contained in the transmission accompanying this notice is confidential and protected by law. It's intended for the use of the doctor listed above. If the reader of this message is not the intended recipient. You are hereby notified that any disseminated or distribution of this communication is prohibited. If you have received this in error, please notify us.

Over

Noblesville Pharmacy

RX and Custom Compounding

FAX COMPLETED PRESCRIPTION

PATIENT INSURANCE INFORMATION (if available)

PATIENT PHONE NUMBER

TO: 317-900-7458

Noblesville Pharmacy • 758 Westfield Drive • Noblesville, IN 46062 • Ph: 317-231-5252

Patient's Hand Out

Noblesville Pharmacy
RX & Custom Compounding

758 Westfield Rd. / Noblesville, IN 46062
T: 317-231-5252 / FAX: 317-900-7458

PLEASE EXPECT a phone call from Noblesville Pharmacy (area code 317) to verify your prescription information. Please make sure you have provided your physician the best phone number so we may contact you.