

Office of: _____
Address: _____
Phone: _____ Fax: _____

Today's Date: _____ Medications Needed By: _____ From: _____
Patient's Name: _____ DOB: _____ Allergies: _____
Home #: _____ Cell #: _____ Work #: _____
Ship Meds To: Infertility Center Patient's Home Other: _____

UNLESS OTHERWISE SPECIFIED, DIRECTIONS FOR ALL MEDICATIONS WILL BE "AS DIRECTED"

- | | | |
|--|---|--|
| <input type="checkbox"/> Clomiphene 50mg
(____ Tabs)(____ Refills)

<input type="checkbox"/> Letrozole 2.5mg
(____ Tabs)(____ Refills)

<input type="checkbox"/> Follistim AQ Cartridge
<input type="checkbox"/> Pens <input type="checkbox"/> BD Pen Needles #10
(____ 300iu)(____ 600iu)
(____ 900iu)(____ Refills)

<input type="checkbox"/> Follistim AQ Vial
(____ 75iu)(____ 150iu)
(____ Refills)

<input type="checkbox"/> Bravelle 75iu
(____ Vials)(____ Refills)

<input type="checkbox"/> Menopur 75iu <input type="checkbox"/> Repronex 75iu
(____ Vials)(____ Refills)

<input type="checkbox"/> Leuprolide Two Week Kit
w/(10) Extra ½cc Insulin Syringes
(____ Kits)(____ Refills)

<input type="checkbox"/> Microdose Leuprolide ____ mcg/____ ml
w/(20) ½cc Insulin Syringes
(____ 10ml Vials)(____ Refills)

<input type="checkbox"/> Cetrotide <input type="checkbox"/> 0.25mg <input type="checkbox"/> 3mg
(____ Kits)(____ Refills)

<input type="checkbox"/> Ganirelix 250mcg/0.5ml
(____ PFS)(____ Refills) | <input type="checkbox"/> Lo Dose hCG ____ iu/____ ml
(____ 5ml Vials)(____ Refills)

<input type="checkbox"/> hCG 10,000iu <input type="checkbox"/> Novarel <input type="checkbox"/> Pregnyl <input type="checkbox"/> BNMN/DAW
(____ Vials)(____ Refills)

<input type="checkbox"/> Ovidrel 250mcg
(____ PFS)(____ Refills)

<input type="checkbox"/> Climara / 4 Patches per Box
<input type="checkbox"/> 0.05mg <input type="checkbox"/> 0.1mg <input type="checkbox"/> BNMN/DAW
(____ Boxes)(____ Refills)

<input type="checkbox"/> Vivelle Dot 0.1 mg (8 patches/box)
Sig: _____
(____ Boxes)(____ Refills)

<input type="checkbox"/> Delestrogen <input type="checkbox"/> 10mg/ml <input type="checkbox"/> 20mg/ml
(____ 5ml Vials)(____ Refills)

<input type="checkbox"/> Estrace <input type="checkbox"/> BNMN/DAW
<input type="checkbox"/> 0.5mg <input type="checkbox"/> 1.0mg <input type="checkbox"/> 2.0mg
(____ Tabs)(____ Refills)

<input type="checkbox"/> Crinone 8% Gel
(____ Apps)(____ Refills)

<input type="checkbox"/> Endometrin Vaginal Inserts 100mg
(____ Inserts)(____ Refills)

<input type="checkbox"/> Progesterone in Oil 50mg/ml
<input type="checkbox"/> Sesame <input type="checkbox"/> Ethyl Oleate
(____ 10ml Vials)(____ Refills)

<input type="checkbox"/> Progesterone in Oil 50mg/ml
<input type="checkbox"/> Cottonseed <input type="checkbox"/> Olive
(____ 15ml Vials)(____ Refills)

<input type="checkbox"/> Progesterone in Ethyl Oleate 100mg/ml
(____ 10ml Vials)(____ Refills) | <input type="checkbox"/> Progesterone (Micronized) Vaginal <input type="checkbox"/> Supp <input type="checkbox"/> Caps
<input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg <input type="checkbox"/> 300mg <input type="checkbox"/> 400mg
(____ Qty)(____ Refills)

<input type="checkbox"/> Prometrium <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg
Sig: _____
(____ Caps)(____ Refills)

<input type="checkbox"/> Doxycycline 100mg
Sig: (1) by Mouth BID
(____ Caps)(____ Refills)

<input type="checkbox"/> Tetracycline 250mg
Sig: (1) by Mouth QID
(____ Caps)(____ Refills)

<input type="checkbox"/> Zithromax 250mg <input type="checkbox"/> BNMN/DAW
(____ Tabs)(____ Refills)

<input type="checkbox"/> Medrol <input type="checkbox"/> BNMN/DAW
<input type="checkbox"/> 4mg <input type="checkbox"/> 8mg <input type="checkbox"/> 16mg
(____ Tabs)(____ Refills)

<input type="checkbox"/> Heparin <input type="checkbox"/> 10,000iu/ml <input type="checkbox"/> 1ml MDV or <input type="checkbox"/> 5ml MDV
<input type="checkbox"/> 20,000iu/ml in 1ml MDV
(____ MDV's)(____ Refills)

<input type="checkbox"/> Lovenox PFS
<input type="checkbox"/> 30mg <input type="checkbox"/> 40mg
(____ PFS)(____ Refills)

<input type="checkbox"/> Other
Sig: _____
(____ Qty)(____ Refills)

<input type="checkbox"/> Other
Sig: _____
(____ Qty)(____ Refills) |
|--|---|--|

If BNMN/DAW is not checked when applicable, generic will be dispensed.

- Sharps Package - No Charge (Sharps disposal unit, alcohol wipes and drug use/information sheets)
- | | |
|---|---|
| <input type="checkbox"/> 3cc <input type="checkbox"/> 18g <input type="checkbox"/> 22g - 1½" Syringe (____ Qty)(____ Refills)
(For: _____) | <input type="checkbox"/> 1cc Syringe (____ Qty)(____ Refills)
(For: _____) |
| <input type="checkbox"/> 18g <input type="checkbox"/> 22g <input type="checkbox"/> 25g - 1½" Needles (____ Qty)(____ Refills)
(For: _____) | <input type="checkbox"/> 3cc Syringe (____ Qty)(____ Refills)
(For: _____) |
| <input type="checkbox"/> 27g <input type="checkbox"/> 30g - ½" Needles (____ Qty)(____ Refills)
(For: _____) | <input type="checkbox"/> Other _____ (____ Qty)(____ Refills)
(For: _____) |

Physician's Signature _____