678 WYCKOFF AVE
WYCKOFF NJ 07481
P 201 891 3334
F 201 891 1312

ANDROPAUSE ORDER FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME:

PRIMARY PHONE #: ○ CELL ○ HOME ○ WORK SECONDARY PHONE #: ○ CELL ○ HOME ○ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

DESCRIPTIONS

Description	Strength
☐ Anastrazole Tablet (30)	1mg
☐ Clomiphene Tablet (30)	50mg
☐ HCG-Pregnyl	10,000 IU vial
☐ HCG-Novarel	5,000 IU vial
☐ HCG-Novarel	10,000 IU vial
☐ HCG-Generic Chorionic Gonadotropin	10,000 IU vial

THE FORMULATIONS BELOW REQUIRE WRITTEN PRESCRIPTION

Description	Strength
☐ Testosterone Cream	________mg/gm
☐ Testosterone SL Tab	○ 25mg ○ 50mg ○ 100mg
☐ Testosterone Cypionate (10ml vial)	200mg/ml
☐ Testosterone Cypionate (1ml vial)	200mg/ml
☐ Testosterone Enanthate (5ml vial)	200mg/ml

Refills: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ PRN ○ NR SIG:____________________

WRITE PRESCRIPTION / ADDITIONAL COMMENTS

DOCTOR PHONE NPI # DEA #

OFFICE MANAGER PHONE OFFICE FAX OFFICE Email

SIGNATURE DATE (Month / Day / Year) ______/_____/______

FAX TO 201-891-1312

email to: orders@yourliferx.com