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Healthwayrx.com

Pharmacist to recommend Bio-identical Hormone Replacement Therapy dosage Female

Dear Healthway Pharmacist:

Please recommend BHRT dosage for the following patient:

Patient Name: _____Date:_____

Patient phone: _____Date of birth: _____

Date of last menstrual cycle: _____

Hysterectomy: ☐ Yes ☐ No Ovaries Removed: ☐ Yes ☐ No

Current Hormone Replacement Therapy: _____

Hormone Levels (Estradiol, Dhea-s, Testosterone, and Progesterone) are attached
-will be faxed to Healthway Pharmacy when received.

Patient has the following issues: (Rank in order of importance)

_____Acne	_____Low Libido
_____Arthritis	_____Night Sweats
_____Breast Tenderness	_____Sleep Disturbances
_____Fibrocystic Breast	_____Uterine Fibroids
_____Fluid Retention	_____Vaginal Dryness
_____Headaches	_____Other_____
_____Hot Flashes	_____

Dr._____Fax:_____

****Once this sheet and hormone levels have been sent to us, please allow 2 business days to receive a recommendation from the pharmacist. The recommendation will not be a prescription, unless approved and written by a licensed prescriber.**