HEALTHWAY COMPOUNDING PHARMACY
40 Years

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Michael E. Collins, RPh, FIACP

Edward Wright, Pharm D.
ABAAHP, FAAMM

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2544 McLeod Dr., N., Ste. 2
Saginaw, MI 48604-2854
989.791.1691
Toll Free: 866.883.8868
Fax: 989.791.4603

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Pharmacist to recommend BHRT 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
History of: ☐Blood clots, ☐Gynecologic Cancer, ☐Other Cancer

Current Hormone Replacement Therapy: _____

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

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

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

Prescriber (print/sign)_____

Fax:_____

****Once this sheet and hormone levels have been sent to us, please allow up to 4 business days to receive a recommendation from the pharmacist. The recommendation will not be a prescription, unless approved and written by a prescriber.**