Henriete D. Faillace, M.D.
2627 NE 203rd St, Suite 101
Aventura, FL 33180
Tel 305 935 2452 Fax 305 937 2622
DEA:

Date_____

Name_____ Allergies:_____

Address _____ _____

_____ D.O.B._____

Rx **Bi-Est** 80:20 or 50:50 _____mg ___ **SR capsule**

Progesterone _____mg per 1 or ____ ___ **SL troche**

Testosterone _____mg ___ **RD Tab**

DHEA _____mg ___ **ml cream**

T3_____**mcg / T4**_____**mcg** ___ **SL gtts**

Other:_____ _____**mg**

Flavor:_____ **Sweetened: yes / no**

QTY _____

Sig: Take _____cap/tab/troche/ml/gtts PO/SL/TOP QAM/QHS/BID or_____

Other sig:_____

Refills _____

_____
Physician's signature (required)

COMPOUNDING DOCS PHARMACY, 5499 N FEDERAL HWY
SUITE L-2, BOCA RATON, FL 33487, 561-826-0711,
CompoundingDocs@fdn.com www.CompoundingDocs.com

Patient phone # ( ) _____E-mail address_____

Please circle payment method: Visa MasterCard Amex Bank Debit

Credit Card # _____ Exp Date:_____

Printed Name of Cardholder _____

Signature _____

<u>This Form may be faxed directly from the physician's office to 561-826-0717</u>