Alpine COMPOUNDING PHARMACY

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TESTOSTERONE FORM

Patient Name: _____ D.O.B.: _____ Phone #: _____

Testosterone Replacement for Women:

Testosterone 1-20% cream or _____ mg/mL cream (example…1mg = 1%, 20 mL = 20%)

Sig: Apply 1 mL topically in the morning %, rub in completely.

Qty: ☐ 30 mL ($90) or ☐ 90 mL ($180) Refills: _____

Physician's Signature: _____ Date: _____