Men's Health Referral Form

Patient Information *(Please provide front and back copy of patient's prescription insurance card if possible)*

Patient Name:	Phone Number:
	Address:
DOB:	
Allergies:	Medical Conditions

Medications

	Compounded Medication	Directions	Quantity	Refills
☐	Dextromethorphan 50mg/Sildenafil 35mg/ Capsules	Use As Directed		
☐	Oxytocin 125u/Tadalafil 40mg Troche	Use As Directed		
☐	Sildenafil 150mg Troche	Use As Directed		
☐	Tadalafil ☐20mg ☐75mg Troche	Use As Directed		
☐	Vardenafil ☐20mg ☐75mg Troche	Use As Directed		
☐	Vardenafil 20mg/Paroxetine 30mg Capsules	Use As Directed		
☐		Use As Directed		
☐		Use As Directed		
☐		Use As Directed		
☐		Use As Directed		

Provider Information

Office Name & Address:		Provider Name:
Phone:	Fax:	DEA#:
DATE:		***Total # of prescriptions:***

_____ Substitution Permissible

_____ Dispense As Written