CUSTOM HEALTH PHARMACY INC.

Date:

HORMONE RESTORATION MANAGEMENT PROGRAM REFERRAL

CUSTOM HEALTH PHARMACY
844 WILLARD DR. SUITE 7
GREEN BAY, WI 54304
P: 920-884-7345 F: 920-884-7346

Dear Pharmacist and Hormone Specialist,

My patient has presented and expressed concern of many symptoms related to hormone imbalance issues. I would like my patient to have their hormones evaluated and tested for appropriately with recommended therapy options. I understand the clinical pharmacist and certified hormone specialist will perform a one-on-one consultation with the patient, run appropriate tests to assess hormones, and follow-up with a recommendation for treatment. I will review the summary and recommendation, and sign off on treatment if I am in agreement. The pharmacist may continue to manage my patient regarding hormone therapy thereafter in continued collaboration with my office. The pharmacist will refer the patient back to primary care services if issues beyond their scope of practice arise.

Sincerely,

_____ _____

Physician signature Printed Name

Office Phone:
Office Fax or Secure Email:

Please provide a direct fax or secure email where pharmacist can send test results with treatment recommendations*

Patient Information
Patient:
DOB:
Home Phone #:
Address: