Your Logo

Address and Contact Information

Name: _____ Date of birth: _____

FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Hot flashes	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches or migraines	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Dry or wrinkled skin	☐	☐	☐	☐	☐
Total score	0				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

Name: _____ Date of birth: _____

HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER

Preventative medicine and bioidentical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as medical doctors, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine). Therefore, bioidentical hormone replacement is not covered by health insurance in most cases.

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

New patient office visit fee ..... $.....

Female hormone pellet insertion fee ..... $.....

We accept the following forms of payment:

.....

Print name: _____

Signature: _____ Date: _____

Your Logo

Address and Contact Information

Name: _____ Date of birth: _____

Date: _____ Diagnosis: ICD10 _____

Re: Reimbursement for services

FEMALE LETTER OF NECESSITY FOR PELLET THERAPY

To whom it may concern:

_____

_____

Pellets are derived from natural plant-based ingredients. They are formulated in specialized 503B compounding pharmacies and possess the exact hormonal structure of the human hormone testosterone. These pellets, once implanted, secrete hormones in tiny amounts into the bloodstream constantly. No other form of testosterone delivery, whether injections, gels, sprays, creams, or patches can produce the consistent blood level of testosterone that pellets can. Pellet therapy is the only method of testosterone therapy that gives sustained and consistent testosterone levels throughout the day, for 3 to 4 months, without a "roller coaster" effect. Other forms of testosterone therapy simply cannot deliver such steady hormone levels.

The dosages are individualized by the physician or practitioner for the patient taking into consideration his current and past medical history as well as prior experience with other forms of therapy, current medications, etc. No other form of therapy has unique dosages which can be tailored to each individual patient to suit his special needs.

The above patient was seen in my office and was diagnosed with:

☐ Testosterone deficiency syndrome and/or ☐ Menopause

Her lab values indicate significant androgen and/or estrogen deficiency. Prior to pellet therapy, the patient experienced:

☐ Decreased libido ☐ Decreased energy ☐ Mood swings ☐ Anxiety ☐ Poor memory

☐ Lack of mental clarity ☐ Joint pain ☐ Lethargy and/or ☐ Other _____

Pellet therapy helps alleviate these symptoms and help improve her quality of life both physically and mentally and has benefited her overall well-being. Please honor her request for reimbursement.

Sincerely,

_____

Doctor or clinic name

Your Logo

Address and Contact Information

Name: _____ Date of birth: _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print name: _____

Signature: _____ Date: _____

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address: _____
Address / City / State / Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

☐ I am sexually active. OR ☐ I want to be sexually active. ☐ I do not want to be sexually active.

☐ I have completed my family. OR ☐ I have NOT completed my family.

☐ My sex life has suffered. OR ☐ I have not been able to have an orgasm or it is very difficult.

Habits:

☐ I smoke cigarettes or cigars _____ per day. ☐ I use e-cigarettes _____ a day. ☐ I use caffeine _____ a day.

☐ I drink alcoholic beverages _____ per week. ☐ I drink more than 10 alcoholic beverages a week.

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other_____

Pertinent medical/surgical history:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Polycystic ovaries/PCOS
- ☐ Acne
- ☐ Excess facial/body hair
- ☐ Infertility
- ☐ Endometriosis
- ☐ Epilepsy or seizures
- ☐ Fibrocystic breast or breast pain
- ☐ Uterine fibroids
- ☐ Irregular or heavy periods
- ☐ Menstrual migraines
- ☐ Hysterectomy with removal of ovaries
- ☐ Partial hysterectomy (uterus only)
- ☐ Ophorectomy removal of ovaries only

Birth control method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ IUD
- ☐ Infertility
- ☐ Other _____

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____

Your Logo

Address and Contact Information

Name: _____ Date of birth: _____

PELLET INSERTION CONSENT FOR FEMALES

My physician/practitioner has recommended bioidentical hormone therapy delivered by a pellet inserted under my skin for treatment of symptoms I am experiencing related to low hormone levels.
The following information has been explained to me prior to receiving the recommended therapy.

OVERVIEW:
Bioidentical hormones are hormones that are biologically identical to that made in my own body. The levels of active estradiol and/or testosterone made by my body have decreased, and therapy using these hormones may have the same or similar effect(s) on my body as my own naturally produced hormones. The pellets are a delivery mechanism for estradiol and/or testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930's. There are other formulations of estradiol and testosterone replacement available, and different methods can be used to deliver the therapy. There are no commercially available forms of testosterone, however, that are formulated specifically for use in women. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

PELLET ACTIVE INGREDIENTS:
I understand that (please initial by the appropriate statement):

_____ I am receiving pellets today that contain testosterone only.

_____ I am receiving pellets today that contain estradiol and testosterone.

_____ I am receiving pellets today that contain testosterone and anastrozole.

RISKS/COMPLICATIONS OF TESTOSTERONE:
Risks associated with pellet insertion may include: bleeding from incision site, bruising, fever, infection, pain, swelling, pellet extrusion which may occur several weeks or months after insertion, reaction to local anesthetic and/or preservatives, allergy to adhesives from bandage(s), steri strips or other adhesive agents.

Some individuals may experience one or more of the following complications with testosterone: acne, abnormal bleeding or a change in menstrual cycle (if patient has a uterus), anxiety, breast or nipple tenderness or swelling, insomnia, depression, mood swings, fluid and electrolyte disturbances, headaches, increase in body hair, fluid retention or swelling, mood swings or irritability, rash, redness, itching, lack of effect (typically from lack of absorption), transient increase in cholesterol, nausea, retention of sodium, chloride and/or potassium, weight gain or weight loss, thinning hair or female pattern baldness, hypersexuality (overactive libido) or decreased libido, overproduction of estrogen (called aromatization) or an increase in red blood cell formation or blood count (erythrocytosis). The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually. Erythrocytosis can be reversed simply by donating blood periodically, but further workup or referral may be required if a more worrisome condition is suspected.

If you are planning to start or expand your family soon, please talk to your provider about other options.

RISKS/COMPLICATIONS OF ESTRADIOL (ONLY APPLICABLE IF RECEIVING ESTRADIOL IN THE PELLETS):
The side-effects of estradiol are similar to those listed above for testosterone. Additionally, there is some risk, even when using bioidentical hormones, that estrogens may cause existing cases of some breast cancers to grow more rapidly. This risk may also apply to some undiagnosed forms of breast cancer.

Using estrogen-alone (without progesterone) may increase the chance of getting cancer of the uterus. Endometrial sampling (biopsy) or surgery may be required if abnormal bleeding occurs.

Please initial if you are postmenopausal, have a uterus, and are getting estradiol.

_____ I understand that I have a uterus and am receiving postmenopausal dosing of estradiol. I agree to take progesterone as directed by my health care provider while receiving estradiol.

RISKS/COMPLICATIONS OF ANASTROZOLE (ONLY APPLICABLE IF RECEIVING ANASTROZOLE IN THE PELLETS):
Anastrozole is a type of medication called an aromatase inhibitor. Aromatase inhibitors limit or prevent the conversion of testosterone into estrogen. Aromatase inhibitors can be used for a variety of conditions but are most commonly used in patients with a history of estrogen receptor positive breast cancer.

Anastrozole should not be used in pregnant women and should be used with caution in women with pre-existing ischemic heart disease. Anastrozole in pellets should not be given to premenopausal women nor to women taking oral aromatase inhibitors (anastrozole or letrozole) or selective estrogen receptor modulators (tamoxifen or raloxifene).

The amount of anastrozole used in pellets is very low. The most common side-effects for women taking anastrozole are hot flashes, joint pain, and muscle pain. Because of the low dose in the pellet, these effects are not usually seen with this type of therapy, however.

CONSENT FOR TREATMENT:
I agree to immediately report any adverse reactions or problems that may be related to my therapy to my physician or health care provider's office, so that it may be reported to the manufacturer. Potential complications have been explained to me, and I acknowledge that I have received and understand this information, including the possible risks and potential complications and the potential benefits.

I also acknowledge that the nature of bioidentical therapy and other treatments have been explained to me, and I have had all my questions answered. I understand that follow-up blood testing will be necessary four (4) weeks after my initial pellet insertion and then at least one time annually thereafter. I also understand that although most patients will receive the correct dosage with the first insertion, some may require dose changes.

I understand that my blood tests may reveal that my levels are not optimal which would mean I may need a higher or lower dose in the future. Furthermore, I have not been promised or guaranteed any specific benefits from the insertion of testosterone pellets.

I accept these risks and benefits, and I consent to the insertion of testosterone pellets under my skin performed by my provider. This consent is ongoing for this and all future insertions in this facility until I am no longer a patient here, but I do understand that I can revoke my consent at any time. I have been informed that I may experience any of the complications to this procedure as described above.

I have read or have had this form read to me.

Witness name: _____ Signature: _____ Date: _____

Print name: _____ Signature: _____ Date: _____

Your Logo

Address and Contact Information

Name: _____ Date of birth: _____

POST-INSERTION INSTRUCTIONS FOR WOMEN

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. It must be removed as soon as it gets wet. The inner layer (usually a steri strip) should be removed in 3 days.
- **Do not take tub baths or get into a hot tub or swimming pool for 3-4 days.** You may shower, but do not remove the bandage or steri-strips for 4 days.
- No heavy lifting or major exercises for the incision area for the next 3-4 days, which includes running, elliptical, squats, lunges, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief (25 to 50 mg orally every 6 hours). Caution: this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks. If the redness worsens after the first 2-3 days, please contact the office.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.
- We recommend putting an ice pack on the area where the pellets are located a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue this for swelling, if needed. Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.

REMINDERS:

- Remember to have your post-insertion blood work done 6 weeks after your FIRST insertion. If you are not feeling any better by 4 weeks, however, please call the office to have your labs drawn early.
- Most women will need re-insertion of their pellets 3-4 months after their initial insertion. If you experience symptoms prior to this, please call the office.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for your next insertion.

ADDITIONAL INSTRUCTIONS:

_____

_____

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print name: _____

Signature: _____ Date: _____

Your Logo

Address and Contact Information

Name: _____ Date of birth: _____

WHAT MIGHT OCCUR AFTER A PELLET INSERTION (FEMALE)

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- INFECTION:
  Is possible with any type of procedure. Infection is uncommon with pellet insertion and occurs in <0.5 to 1%. If redness appears and seems to worsen (rather than improve), is associated with severe heat and/or pus, please contact the office. Warm compresses are helpful, but a prescription antibiotic may also be needed.
- PELLET EXTRUSION:
  Pellet extrusion is uncommon and occurs in <5% of procedures. If the wound becomes sore again after it has healed, begins to ooze or bleed or has a blister-type appearance, please contact the office. Warm compresses may help soothe discomfort.
- ITCHING or REDNESS:
  Itching or redness in the area of the incision and pellet placement is common. If you have a reaction to the tape, please apply hydrocortisone 2-3 times per day to the rash. If redness becomes firm or starts to spread after the first few days, you will need to contact the office.
- FLUID RETENTION/WEIGHT GAIN:
  Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.
- SWELLING of the HANDS & FEET:
  This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, or by taking a mild diuretic, which the office can prescribe.
- BREAST TENDERNESS or SWELLING:
  This usually occurs most commonly in the first round of pellets but does not usually continue thereafter. DIM 1 capsule daily is helpful in preventing this, but the dose may be increased to 2-3 daily, if needed. Evening primrose oil (available in our office) is helpful as is Iodine+ if this occurs.
- MOOD SWINGS/IRRITABILITY/ANXIETY:
  These may occur if you were quite deficient in hormones. These symptoms usually improve as hormone levels improve. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.
- ELEVATED RED CELL COUNT
  (most common in men):
  Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition is called erythrocytosis. Erythrocytosis may also occur in some patients independent of any treatments or medications. If your blood count goes too high, you may be asked to see a blood specialist called a hematologist to make sure there is nothing worrisome found. If there is no cause, the testosterone dose may have to be decreased.
- HAIR LOSS:
  Is rarely due to pellets but can occur in some patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases. Workup for other causes may also be needed.
- FACIAL BREAKOUT:
  Some pimples may arise if the testosterone levels are either too low or rise rapidly. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.
- UTERINE SPOTTING/BLEEDING/
  IRREGULAR PERIODS:
  This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem.
- HAIR GROWTH:
  Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. Fine, vellous hairs or “peach fuzz” often occurs but is not thick nor coarse. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print name: _____

Signature: _____ Date: _____

Your Logo

Address and Contact Information

Name: _____ Date of birth: _____

FEMALE TREATMENT PLAN

- The following medications or supplements are recommended in addition to your pellet therapy.
- It is best to take these vitamins and/or supplements after eating.
- **If you are currently taking estrogen replacement, please stop after 3 days; if you are using another form of testosterone, please stop after 7 days.**

SUPPLEMENTS: **These are available in our office for your convenience. For best results, please take the supplements recommended for you. Take all supplements or vitamins AFTER a meal.**

_____ ADK 5 or _____ ADK 10 - take 1 daily or as directed.

_____ Arterosil - take 1 capsule twice daily; take 1 capsule 3x daily if taking for diabetic neuropathy.

_____ BPC-157 - take 2 capsules per day with water or as directed.

_____ Bacillus Coagulans - take 1 daily or as directed.

_____ Curcumin SF - take 1-2 twice daily.

_____ DIM SGS+ - take 1 daily.

_____ Deep Sleep - take 2 capsules 30 minutes before bed or as directed.

_____ Iodine+ - start by taking 2-3x weekly and gradually increase to daily dosing; start Iodine+ about 4 weeks after your first round of pellets.

_____ Methyl Factors+ - take 1 daily or as directed based on B12 or other lab results.

_____ Multi-Strain Probiotic 20B - take 1 to 2 weekly then increase after 1 month to 1 daily.

_____ Omega 3 + CoQ10 - take 1-2 twice daily.

_____ Senolytic Complex - take 1 capsule per day with water or as directed.

_____ Serene - take 1 or 2 capsules with water as needed. Effects typically start to diminish after 3-4 hours. Dosing may vary.

_____ Other _____

PRESCRIPTIONS: **These have been called into your preferred pharmacy**

_____ Progesterone _____ 200 mg generic OR _____ 225 mg compounded OR _____ 100 mg cmpd sublingual.

If you are POSTMENOPAUSAL, have a uterus, and received estrogen replacement, please do not skip doses of progesterone as it can result in vaginal bleeding or an increased risk for endometrial cancer.

_____ NP Thyroid _____ mg every morning on an empty stomach; wait 30 minutes before putting anything else on your stomach including coffee, food, or other medications.

_____ Wean off Synthroid/Levothyroxine: alternate your desiccated thyroid (NP Thyroid or Armour) every other day with Synthroid/Levothyroxine for 3 weeks then go to every day on your desiccated thyroid.

_____ Spironolactone _____ mg daily; start with 1/2 tablet daily and increase slowly to daily use in AM.

_____ Wean off your antidepressant (see wean protocol) _____ Other _____

Please call or email for any questions about these recommendations.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print name: _____

Signature: _____ Date: _____