



Female New Patient Package

The contents of this package are your first step to restore your vitality.

Please take time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio-identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical® can help you live a healthier life. **Please complete the following tasks before your appointment:**

2 weeks or more before your scheduled consultation: Get your blood labs drawn at any Quest Diagnostics or LabCorp. If you are not insured or have a high deductible, call our office for self-pay blood draws. We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to. **Please note that it can take up to two weeks for your lab results to be received by our office.**

Your blood work panel MUST include the following tests:

- Estradiol
- FSH
- Testosterone Total
- TSH
- T4, Total
- T3, Free
- T.P.O. Thyroid Peroxidase
- CBC
- Complete Metabolic Panel
- Vitamin D, 25-Hydroxy (Optional)
- Vitamin B12 (Optional)
- Lipid Panel (Optional) (**Must be a fasting blood draw to be accurate**)

Female Post Insertion Labs Needed at 4, 6 or 8 Weeks based on your practitioner's choice:

- FSH
- Testosterone Total
- CBC
- Lipid Panel (Optional) (**Must be a fasting blood draw to be accurate**)
- TSH, T4 Total, Free T3, TPO (**Needed only if you've been prescribed thyroid medication**)
- Estradiol



Female Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via E-Mail? () 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've 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.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

- () I am sexually active.
- () I want to be sexually active.
- () I have completed my family.
- () My sex has suffered.
- () I haven't been able to have an orgasm.

Habits:

- () I smoke cigarettes or cigars _____ per day.
- () I drink alcoholic beverages _____ per week.
- () I drink more than 10 alcoholic beverages a week.
- () I use caffeine _____ a day.



Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? () Yes () No

If yes, please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

- () Medical/GYN exam in the last year.
- () Mammogram in the last 12 months.
- () Bone density in the last 12 months.
- () Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:

- () Breast cancer.
- () Uterine cancer.
- () Ovarian cancer.
- () Hysterectomy with removal of ovaries.
- () Hysterectomy only.
- () Oophorectomy removal of ovaries.

Birth Control Method:

- () Menopause.
- () Hysterectomy.
- () Tubal ligation.
- () Birth control pills.
- () Vasectomy.
- () Other: _____

Medical Illnesses:

- () Polycystic Ovary Syndrome (PCOS)
- () High blood pressure.
- () Heart bypass.
- () High cholesterol.
- () Hypertension.
- () Heart disease.
- () Stroke and/or heart attack.
- () Blood clot and/or a pulmonary emboli.
- () Arrhythmia.
- () Any form of Hepatitis or HIV.
- () Lupus or other auto immune disease.
- () Fibromyalgia.
- () Trouble passing urine or take Flomax or Avodart.
- () Chronic liver disease (hepatitis, fatty liver, cirrhosis).
- () Diabetes.
- () Thyroid disease.
- () Arthritis.
- () Depression/anxiety.
- () Psychiatric disorder.
- () Cancer (type): _____

Year: _____



Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name: _____
(Last) (First) (Middle)

Today's Date: _____

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: (please circle)

Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

Print Name

Signature

Today's Date



BHRT Checklist For Women

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		



Hormone Replacement Fee Acknowledgment

Although more insurance companies are reimbursing patients for the BioTE® Medical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure. All claims must be filed as OUT OF NETWORK, since BioTE is not credentialed with any insurance company. We will give you paperwork to send to your insurance company to file for reimbursement upon request.

New Patient Consult Fee	\$125.00
Female Hormone Pellet Insertion Fee	<u>+\$350.00</u>
You will pay for first procedure:	\$ 475.00
<u>Subsequent procedures will be \$300.00 (Approximately every 3 to 5 months)</u>	

WE DO NOT FILE INSURANCE ON THIS PROCEDURE – AND IT IS OUT OF NETWORK

We accept the following forms of payment: Master Card, Visa, Discover, American Express, Personal Checks, Care Credit and Cash. You can also prepay over a period of months.

INSURANCE DISCLAIMER

Preventative medicine and bio-identical 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 and RN's or NP's, insurance does not recognize it as necessary medicine BUT is considered like plastic surgery (esthetic medicine) and therefore is not covered by health insurance in most cases.

GTFCC Health & Wellness Tax ID# 46-5543073 is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket for out of network services. WE WILL NOT, however, communicate in any way with insurance companies.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead 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. We do not pre-certify or obtain pre-authorization for this service since it is an out of network service.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best idea for those patients who have an HSA as an option in their medical coverage. By signing this document, you are agreeing with the terms of this service and understand it is an out of network procedure.

Print Name

Signature

Today's Date



WHAT MIGHT OCCUR AFTER A PELLETT INSERTION

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.

- **FLUID RETENTION:** 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, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.
- **UTERINE SPOTTING/BLEEDING:** 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. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.
- **MOOD SWINGS/IRRITABILITY:** These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.
- **FACIAL BREAKOUT:** Some pimples may arise if the body is very deficient in testosterone. 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.
- **HAIR LOSS:** Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.
- **HAIR GROWTH:** Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. 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

Today's Date



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 is either waterproof foam tape or steri-strips. They should be removed in **3 days**.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours.
- Do not take tub baths or get into a hot tub or swimming pool for **3 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next **3 days**, this 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, 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.
- 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.

Reminders:

- Remember to go for your post-insertion blood work **6 weeks** after the insertion.
- Most women will need re-insertions of their pellets **3-4 months** after their initial insertion.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. The charge for the second visit will only be for the insertion and not a consultation.

Additional Instructions:

I acknowledge that I have received a copy and understand the instructions on this form.

Print Name

Signature

Today's Date



Mammogram Waiver for Testosterone and/or Estradiol Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone and/or estradiol pellet therapy, even though I am not current on my yearly mammogram. I understand that such therapy is controversial and that many doctors believe that estradiol replacement in my case is contraindicated. My Treating Provider has informed me it is possible that taking estradiol could possibly cause cancer, or stimulate existing breast cancer (including one that has not yet been detected). Accordingly, I am aware that breast cancer or other cancer could develop while on pellet therapy.

For today's appointment I DO NOT have a mammogram for the following reason:

My decision not to have one.

Unable to provide the report at this time.

My doctor's decision not to have one. Please provide a note from your treating physician with their rationale as to why they don't want you to have a mammogram.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive testosterone and/or estradiol. _____ (initials of patient)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast, uterine or cancer issues) that may be sustained by me in connection with my decision to not have a mammogram and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives

Patient Print

Name Signature

Today's Date



PAP and Transvaginal Ultrasound Waiver for Testosterone and/or Estradiol Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous bio- identical testosterone and/or estradiol pellet therapy.

() For today's appointment I DO NOT have a PAP Smear for the following reason:

- () My decision not to have one.**
- () Unable to provide the report at this time.**
- () My doctor's decision not to have one. Please provide a note from your treating physician with their rationale as to why they don't want you to have a PAP Smear.**

() For today's appointment I DO NOT have a Transvaginal Ultrasound for the following reason:

- () My decision not to have one.**
- () Unable to provide the report at this time.**
- () My doctor's decision not to have one. Please provide a note from your treating physician with their rationale as to why they don't want you to have a Transvaginal Ultrasound.**

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a Pap smear and/or Transvaginal Ultrasound since I receive testosterone and/or estradiol. _____ (initials of patient)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that PAP smear and/or Transvaginal Ultrasounds are the best single method for detection of early ovarian, endometrial and/or cervical cancer. I understand that my refusal to submit to a Pap smear and/or Transvaginal Ultrasound may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or cervical, endometrial and/or ovarian cancer issues) that may be sustained by me in connection with my decision to not have a PAP Smear and/or Transvaginal Ultrasound and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives

Patient Print Name

Signature

Today's Date



Commonly Asked Questions

Q. What is BioTE®?

A. BioTE® is a Bio-Identical form of hormone therapy that seeks to return the hormone balance to youthful levels in men and women.

Q. How do I know if I'm a candidate for pellets?

A. Symptoms may vary widely from depression and anxiety to night sweats and sleeplessness for example. You will be given a lab slip to have blood work done which will determine your hormone levels. Once the doctor reviews and determines you are a candidate we will schedule an appointment for insertion.

Q. Do I have blood work done before each Treatment?

A. No, only initially and 4-8 weeks later to set your dosing. You may have it done again if there are significant changes.

Q. What are the pellets made from?

A. They are made from wild yams and soy. Wild yams and soy have the highest concentration of hormones of any substance. There are no known allergens associated with wild yams and soy, because once the hormone is made it is no longer yam or soy.

Q. How long will the treatment last?

A. Every 3-6 months depending on the person. Everyone is different so it depends on how you feel and what the doctor determines is right for you. If you are really active, you are under a lot of stress or it is extremely hot your treatment may not last as long. Absorption rate is based on cardiac output.

Q. Is the therapy FDA approved?

A. What the pellets are made of is FDA approved and regulated, the process of making pellets is regulated by the State Pharmacy Board, and the distribution is regulated by the DEA and Respective State Pharmacy Boards. The PROCEDURE of placing pellets is NOT an FDA approved procedure. The pellets are derived from wild yams and soy, and are all natural and bio-identical. Meaning they are the exact replication of what the body makes.

Q. How are they administered?

A. Your practitioner will implant the pellets in the fat under the skin of the hip. A small incision is made in the hip. The pellets are inserted. No stitch is required.

Q. Does it matter if I'm on birth control?

A. No, the doctor can determine what your hormone needs are even if you are on birth control.

Q. Are there any side effects?

A. The majority of side effects is temporary and typically only happens on the first dose. All are very treatable. There are no serious side effects.

Q. What if I'm already on HRT of some sort like creams, patches, pills?

A. This is an easy transition. The doctor will be able to determine your needs even though you may be currently taking these other forms of HRT.

Q. What if I've had breast cancer?

A. Breast cancer survivors and/or those who have a history of breast cancer in their family may still be a candidate; however, this is to be determined by the physician. You should schedule a consultation with the Doctor.



INSURANCE DISCLAIMER

Preventative medicine and bio-identical 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 and RN's or NP's, insurance does not recognize it as necessary medicine BUT is considered like plastic surgery (esthetic medicine) and therefore is not covered by health insurance in most cases. **The Procedure Code is 11980 – CPT.**

GTFCC HEALTH & WELLNESS PLLC – TAX ID # 46-5543073 is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies. **BioTE pellet insertion procedure can only be processed as out of network.** The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead 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. This is the best idea for those patients who have an HSA as an option in their medical coverage.

Name: _____ Signature: _____ Date: _____

Instructions on filing your insurance for reimbursement

- 1. Obtain your insurance form from your insurance company (usually from their web site)**
- 2. Make three copies of the LETTER OF MEDICAL NECESSITY, SUPERBILL, and COMPLETED CLAIM FORM (from the insurance web site).**
- 3. Mail one of each of the above documents to the claims address on the back of your insurance card.**
- 4. Call your insurance company in 3 weeks to verify they have received your claim and the status. Document the name of the person you speak with.**
- 5. If they do not have the claim on file yet, ask if you can fax the claim to them and/or verify the mailing address. Send the second set of documents.**
- 6. Repeat steps 4 and 5 until your claim is processed or paid. Not all insurances will cover this therapy since the pellets are compounded.**
- 7. You must have “OUT OF NETWORK” benefits for this to be reimbursed by your insurance and have met the “OUT OF NETWORK” deductible.**



Female Treatment Plan

- ° The following medications or supplements are recommended in addition to your pellet therapy.
- ° Please refer to the supplement brochure to help you understand why these are beneficial.
- ° Unless specified, these can be taken any time of day without regards to meals.

Supplements: These may be purchased in our office. When you run out they can be mailed to you for your convenience.

_____ ADK 5,000 (vitamins A, D3 and K2)
 _____ 1 a day _____ 2 a day for _____ weeks, then one a day

_____ ADK 10,000 (vitamins A, D3 and K2)
 _____ 1 a day _____ 2 a day for _____ weeks, then one a day

_____ Probiotic Take 1 a day for one week, then take 2 a day starting week 2
 _____ Omega 3 Take 1 -4 softgels a daily with meal
 _____ BioTE Iodine Plus 12.5 mg daily with food or as directed by physician
 _____ DIM Take 1 a day

Prescriptions: These have been called into your preferred pharmacy

_____ **Progesterone/Prometrium** nightly
 _____ 100 mg _____ 200 mg

Please do not skip doses of this medication as it can result in vaginal bleeding or an increased risk for endometrial cancer.

_____ **Nature-throid** _____ mg every morning. This should be taken on an empty stomach. Please wait 30 minutes before putting anything else on your stomach. This includes coffee, food, medications, vitamins or supplements. _____ Sample given

_____ Wean off Synthroid/levothyroxine: alternate your desiccated thyroid (Nature-throid) every other day with Synthroid/levothyroxine for 3 weeks then go to every day on your desiccated thyroid.

_____ Spironolactone 100 mg daily _____ (other) _____

_____ 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 Today's

Date