Bio-Identical Hormone Replacement Therapy Assessment and Evaluation Checklist

These items must be completed and on file with the pharmacy prior to your assessment:

Have your doctor complete the Pharmacist-Physician Collaboration Agreement.

Pharmacy Record Release Authorization Form

Confidential Medical History Form

Hormone Replacement Therapy Patient Information Sheet

Question Documentation Form

Provide copies of any relevant blood and/or saliva tests results if available (ie. estradiol, estriol, estrone, progesterone, testosterone, cortisol, etc.)

Mail all materials and a personal check or money order for the Assessment and Evaluation fee ($75) made out to Pine Pharmacy.

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(P) 716.332.2288 (F) 716.332.2287

Pharmacist-Physician Collaboration Agreement

Your patient, _________________________________, has requested a *Bio-Identical Hormone Assessment* by our pharmacists. This assessment includes but is not limited to a review of symptoms, medical history, family history, and any pertinent lab work. Upon completion, recommendations and suggestions will be forwarded to you for review and approval. Recommendations may include prescriptions for bio-identical hormones, nutritional supplements, and lifestyle modifications.

I, ____ (Physician Name), authorize **Pine Pharmacy** to assess and

evaluate ____ (Patient Name), and make recommendations to me

regarding my patient's bio-Identical hormone treatment.

Signature: ____ Date: _________________________

Pharmacy Record Release Authorization

I, the undersigned patient authorize my pharmacist to release my personal medication and/or other medical information to the following persons or organizations upon request or as deemed necessary:

Name	Address	Telephone
1)		
2)		
3)		

I understand that employees of Pine ______________ Pharmacy will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Patient Name: ______________________________

Address: ______________________________

City, State, Zip ______________________________

Phone: ______________________________

Signature: ______________________________

Date: ______________________________

Patient Name:

Confidential Medical History Form

Please return your form to the Pharmacy when you have finished.
The Pharmacist will meet with you to review your information. Thank you.

Today's Date: ______________________

Name: ______________________ Birthdate: __________ Age: __________

Address: ____

City: ______________________ ST: __________ Zip: ______________________

Phone: ______________________________ Email: __________________

Gender: Female Male Height: __________ Weight: __________

	Yes or No	If YES, how often & how much?
Do you use tobacco?		
Do you use alcohol?		
Do you use caffeine?		

Doctor's Name:	**Address:**	**Phone:**

Allergies: Please check all that apply:

___ Penicillin	___ Morphine	___ Dye allergies	___ Pet allergies
___ Codeine	___ Aspirin	___ Nitrate allergies	___ Seasonal (pollen)
___ Sulfa drug	___ Food allergies	___ No known allergies	___ other

Please describe the allergic reaction you experienced and when it occurred:

Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain Reliever	___ Combination product, cough+cold reliever (ex:Triaminic®)
___ Aspirin	___ Sleep aids (ex:Excedrin PM®, Unisom®, Sominex®)
___ Acetaminophen (ex:Tylenol®)	___ Antidiarrheals (ex:Imodium®,PeptoBismol®, Kaopectate®
___ Ibuprofen (ex:Motrin IB®)	___ Laxatives/stool softeners (ex:Doxidan®, Correctol®)
___ Naproxen (ex:Aleve®)	___ Diet aids/weight loss products (ex:Dexatrim®)
___ Ketoprofen (ex:Orudis KT®)	___ Antacids (ex:Maalox®, Mylanta®)
___ Cough suppressant (ex:Robitussin DM®)	___ Acid blockers (ex:Tagamet HB®,Pepcid AC®,Zantac 75®)
___ Antihistamine product (ex:Chlor-Trimeton®)	___ Other (please list:)
___ Decongestant product (ex:Sudafed®	______________________

Nutritional/Natural Supplements: Please identify and list the products you are using:

____ Vitamins (ex: multiple or single vitamins such as B complex, E, C, beta carotene)

____ Minerals (ex: calcium, magnesium, chromium, colloidal minerals, various single minerals)

____ Herbs (ex: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc)

____ Enzymes (ex: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc)

____ Nutrition/protein supplements (ex: shark cartilage, protein powders, amino acids, fish oils, etc)

____ Others (ex: glucosamine, etc.)

Medical Conditions/Diseases Please check all that apply to you.

____ Heart disease (ex: Congestive Heart Failure)
____ High cholesterol or lipids (ex: Hyperlipidemia)
____ High blood pressure (ex: Hypertension)
____ Cancer
____ Ulcers (stomach, esophagus)
____ Thyroid disease
____ Hormonal related issues
____ Blood clotting problems
____ Lung condition (ex: asthma, emphysema, COPD)
____ Diabetes
____ Arthritis or joint problems
____ Depression
____ Epilepsy
____ Headaches/migraines
____ Eye disease (glaucoma, etc)
____ Other: Please list: ____________

Current Prescription Medications:

	Medication Name	Strength	Date Started	How often per day
1				
2				
3				
4				
5				
6				

List Hormones previously taken.	Date Started	Date Stopped	Reason

Bone Size: ________ Small ________ Medium ________ Large

Body Type: ________ Androgenic ________ Estrogenic

Have you ever used oral contraceptives? ________ No ________ Yes

Any problems? No ________ Yes If yes, please describe below.

How many pregnancies have you had? ________ How many children? ________

Any interrupted pregnancies? ________ No ________ Yes

Patient Name:

Have you had a hysterectomy? ___________ No ___________ Yes Date of surgery ________________

Ovaries removed? ________ No ________ Yes

Have you had a tubal ligation? ________ No ________ Yes Date __________________________

Do you have a family history of any of the following?

Uterine Cancer ___________ Family member(s) ____

Ovarian Cancer ___________ Family member(s) ____

Fibrocystic breast ___________ Family member(s) ____

Breast Cancer ___________ Family member(s) ____

Heart Disease ___________ Family member(s) ____

Osteoporosis ___________ Family member(s) ____

Have you had any of the following tests performed?
Check those that apply and note the date of last test.

Mammography ________ No ________ Yes Date: ________________________________

PAP Smear ________ No ________ Yes Date: ________________________________

Since you first began having periods, have you ever had what YOU consider to be abnormal cycles?

________ No ________ Yes Date: ____

Please explain:

____

When was your last period? ____

How long did it last? ____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ________ No _________ Yes

If YES, please explain symptoms:

____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

Doctor _________ Self _________ Friend/Family Member ___________ Other _________

What are your goals with taking BHRT?

Patient Name:

Hormone Replacement Therapy Patient Information Sheet

Name ____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences with one being Extremely Mild and ten being Extremely Severe.

	1	2	3	4	5	6	7	8	9	10
Sleep Disruptions	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Nervousness	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10
Hot Flashes	1	2	3	4	5	6	7	8	9	10
Dry Skin	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Arthritis	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10

____

Question Documentation Form

Please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (Rx BHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist/nurse. Thank you.

1.

2.

3.

4.

5.

Patient Name:

Frequently Asked Questions

Q. When will I be contacted after submitting all of the materials?

A. It is not uncommon to wait two (2) weeks before receiving initial therapy recommendations. At the time Pine Pharmacy receives the materials an assessment and evaluation is performed. You will be contacted with any questions. A formal assessment and plan with therapy recommendations is sent to your doctor. Once authorization from your doctor is received you will be contacted with your treatment regimen.

Q. After my initial treatment regimen how am I monitored?

A. Our pharmacists are always available for questions during normal business hours. After 90 days you will receive a follow-up questionnaire. Monitoring from that point on will be annual or as needed.

Q. How long before I notice symptomatic relief?

A. Symptomatic relief varied depending on the symptom and specific hormone regimen; anywhere from a few days to several weeks in certain situations.

Q. Are there any side effects?

A. As with any medication there is always a possibility of side effects. The pharmacist will consult you on these possibilities.

Q. What dosage forms do you provide?

A. Bio-Identical hormones are commonly compounded into capsules, creams, and lozenges. The pharmacist and physician will determine the most appropriate and convenient dosage form for you.

Q. Is the assessment and evaluation fee covered by my insurance?

A. No.

Q. Are the prescriptions covered by my insurance?

A. Many are but, depending on the insurance and specific hormone prescribed, individual coverage benefits may vary.

Q. Do I need blood or saliva tests?

A. No, we take any lab work into consideration if available. If not, treatment recommendations are made based on the clinical picture, including, but not limited to: family history, past medical history, and symptoms.