

Thyroid (Desiccated/Natural) Order Form

(Please Call or Fax the Completed Form)

Patient name:	Allergies:
Phone: ()	D.O.B: / /

Please Compound the Following Strength of Natural T4/T3 (long-acting)

Qty	Dosage / mg	Dosage in / Grain	T4/T3
	15mg	1/4 Grain	9.5mcg/2.25mcg
	30mg	1/2 Grain	19mcg/4.5mcg
	45mg	3/4 Grain	28.5mcg/6.75mcg
	60mg	1 Grain	38mcg/9mcg
	90mg	1.5 Grain	57mcg/13.5mcg
	120mg	2 Grain	76mcg/18mcg
	150mg	2.5 Grain	95mcg/22.5mcg
	180mg	3 Grain	114mcg/27mcg
	210mg	3.5 Grain	133mcg/31.5mcg
	240mg	4 Grain	152mcg/36mcg
	Other: _____	Other: _____	Other: _____
	Other: _____	Other: _____	Other: _____

Sig: Take _____ Capsule(s) _____ Time(s) a day on empty stomach, at least 1 hour before food.

Refill: _____ times or until this date: _____

Dr. Name: _____ **Tel# :** (_____) _____

Physician Signature: _____ **DEA#:** _____

Notes/Other Instructions: _____

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