AFFINITY™ PHYSICIAN NETWORK

Men's TCore20™ Prescription Order Form #1

Patient Information:

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Allergies: _____

Email: _____

Testosterone Product (please use the check boxes below for selection)

PRODUCT	DOSAGE & ADMINISTRATION
☐ 2 vials Testosterone Cypionate 200mg/ml (10ml vial)	Intramuscular 1ml injection 1x per week

Dosage Modifications (if needed): ☐ 0.25ml ☐ 0.50ml ☐ _____ ml

Frequency Modifications (if needed): ☐ 1x/week ☐ 2x/week

Administration Ancillaries (please use the check boxes below for selection)

☐ 22 syringes 20g 3ml w/ draw-tip / 22 needle tips 23g 1" / 100 alcohol prep pads *for 1x per week*

☐ 44 syringes 20g 3ml w/ draw-tip / 44 needle tips 25g 5/8" / 100 alcohol prep pads *for 2x per week*

*All TCore20™ Programs and individual product options include patient home-delivery cost when ordered together

*Any individual product options not ordered with a TCore20™ Program will require a separate shipping charge of $25.00

Doctor & Clinic Information:

Affinity Physician Network
6180 Halle Drive Suite B Valley View, Ohio 44125
Phone: (216)-273-8700
Fax: (216)-290-1210
Email: tcore20@hrtnetwork.com

Prescriber Name: _____

DEA #: _____

State License #: _____

Prescriber Signature: _____

Date: _____

(month must be spelled out, i.e. March 1, 2017)

Special Instructions:

_____

_____

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