



620 Guilbeau Road • Suite A
Lafayette, Louisiana 70506
337-991-0101 Fax 337-991-9844

Welcome to Professional Arts Pharmacy.....We are a pharmacy for SPECIAL needs PATIENTS.

As a patient referral, we understand that you are coming to us with SPECIAL NEEDS. We will work with YOU and with YOUR PHYSICIAN within the **TRIAD of CARE** to address your healthcare concerns.

The TRIAD consists of the PATIENT - the PHYSICIAN - and the PHARMACIST. It is important that we gather important information from you and your physician about your health history. This accumulated data is valuable for consideration in the preparation of the dosing recommendation report that will be forwarded to your physician for final approval.

Patient Instructions for Consultation Services:

1- Hormone Replacement Evaluation Form

To be completed prior to making appointment or consult which includes medical and hormonal health history information.

2-Current Labwork

It is very important to perform serum (blood testing) on all hormones before starting treatment. Included in the packet is a list of test you should have done. Please remember to sign a release form from your physician for current lab results that will be forwarded to us. Upon your request, we can send a letter to your doctor to request particular lab test. All test results should be sent **PRIOR** to scheduling an appointment with Clinical Pharmacist, Mandie E. Romero, P.D.

3- Consultation Fees

Once the test results have been received and all of your additional labs and information have been forwarded to the pharmacy, you will be contacted to arrange a consultation appointment. One hour of time is allotted for each appointment and charges are based on actual length of appointment. The current charge is \$125.00 for initial consult.

Hormone testing is highly recommended prior to appointment. If you have had testing done recently, please speak with Mandie Romero, P.D. before performing any testing. If you have further questions, you may call anytime, Monday through Friday. Please ask for my office assistant, Jennifer. She will assist with basic questions and preliminary information.

Sincerely,

Mandie E. Romero, P.D.,
Clinical Pharmacist

Consulting Service Fee Schedule

Initial consultation \$125.00

The initial consultation fee includes a 1-hour consultation, 3 follow-up phone calls, and 2-30 minute consultations with Clinical Pharmacist, Mandie E. Romero, P.D. within the first year of initial consultation.

Additional consultations

For a 30minute phone call or office visit \$35.00

For a 1-hour phone call or office visit \$50.00

Lab work review \$50.00

Annual consultation \$75.00

Prior to scheduling your annual visit, the patient should retest hormone levels. The annual visit will include an hour visit to discuss symptoms and any current lab work including salivary hormone levels.

CONSULTATION PROCEDURE

To the patient:

Your medical information is confidential and will be handled according to our privacy policy.

The time required for this review, the preparation of the preliminary medical information summary, the final report, and communication with your physician are included in your initial consultation charges.

The consultation appointment will last approximately one hour.

After this meeting a report will be prepared by the Consultant Pharmacist and faxed to you physician. This report will be a summary of your information with dosing recommendations that must be APPROVED BY YOUR PHYSICIAN.

Review and Approval may take 7-10 business days.

Once we receive authorization from you physician your medications will be prepared.

You will be contacted when the medications are ready to be picked up. One of your pharmacists will sit with you to explain your dosing schedule and devices if necessary.

If changes should become necessary, keep in mind that your physician must approve changes. This may take 7-10 business days.

If a refill is due and the review is not complete, changes will not be processed until the next refill. Do not stop medication or adjust does unless directed to do so.

Patient Signature: _____ **Date:** _____

**Bio-Identical Hormone Replacement
Confidential Evaluation**

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided in the questions below will allow the pharmacist to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential.

GENERAL INFORMATION

Date: _____

Name: _____ Age: _____ Birth Date: _____

Street Address _____ Apt. _____

City: _____ State _____ Zip: _____

Occupation: _____ Full-Time Part-Time Retired Unemployed Other

Phone Day: _____ Cell: _____ Evening: _____

Living Situation: Spouse Alone Partner(s) Parents Children Other

How did you hear about Bio-Identical Hormone Replacement Therapy: Ad Another Patient
 Friend Physician/Healthcare Practitioner Books/Articles Course/Seminar Other

If referred, who referred you? _____

Do you understand what Bio-Identical Hormone Replacement is? _____

What are your goals for Hormone Replacement Therapy? _____

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

Other Physicians Currently Seeing: _____

MEDICAL STATUS

General Health:

Excellent Good Fair Poor

Height _____ Weight _____

Blood Type: O A B AB

Ethnic Heritage: _____

Current Diagnosis or Medical Conditions:

Current Medications: (use back side of form if needed) *

Medication/Strength	Daily Dose	Why are you using medication?

* Please check this box if you added information to back of form.

Drug Allergies: (use back side of form if needed) *

Medication	Response

* Please check this box if you added information to back of form.

Allergies to food, other, etc.: (use back side of form if needed) *

Food, etc.	Response

* Please check this box if you added information to back of form.

Current Vitamins, Herbals, OTC products, other products being used: (use back side of form if needed) *

Supplement/Strength	Daily Dose	Why are you using product?

* Please check this box if you added information to back of form.

Are you using any androgens OTC or Prescription (ex: DHEA, Testosterone or Androstenedione)?

Y N

If yes, please give brand name: _____

How long have you been using this product _____

How much are you using and what is the frequency of dosing: _____

History of Hormone Therapy Use: (please list, starting with first medication used)

Date Started	Hormone/Strength	Daily Dose	Reason for Change

Exam/Lab Results: Any lab results you may wish to enclose would be helpful for your evaluation.

	DATE	SERUM BLOOD	SALIVA	RESULTS
FSH				
LH				
PSA				
PROLACTIN				
ESTRADIOL (E2)				
PROGESTERONE				
TESTOSTERONE				
TOTAL				
FREE				
CORTISOL AM				
CORTISOL PM				
DHEA SULFATE				
SHBG				
TRYGLYCERIDES				
CHOLESTEROL:				
TOTAL				
HDL				
LDL				

Bone Density Test:

Type: DEXA Scan

N-Telopeptide, Urine

Date	BL NTx	Spine BMD	Spine T-Score	Spine Z-Score	Hip BMD	Hip T-Score	Hip Z-Score

Have you ever had a Prostate Exam: Y N Date: _____ Results: _____

Have you ever had Prostate Cancer or Enlarged Prostate (BPH)? Y N

Date: _____

Thyroid tests: Y N

Date: _____

Serum Blood Spot

TSH: _____ T4: _____ Free T3: _____ rT3: _____ RIA T3: _____

LIFESTYLE:

Dietary Restrictions: _____

Meal Choices: Breakfast: _____

Lunch: _____

Dinner: _____

Do you get routine exercise: _____ What type: _____ How often: _____

Do you use tobacco products: Y N How much: _____ How Long: _____

Do you use alcohol products: Y N How much: _____ How Long: _____

Do you use caffeine products: Y N How much: _____ How Long: _____

Stressors in your life: _____

CURRENT AND PAST MEDICAL CONDITIONS:

Please check the ones that apply to you.

	Y	N	Date of Diagnosis		Y	N	Date of Diagnosis
Heart Disease				High Blood Pressure			
Stroke				Varicose Veins			
Clotting Defects				Diabetes			
Kidney Trouble				Epilepsy			
Fractures				Arthritis			
Colitis				Gallbladder trouble			
Irritable Bowel				Asthma			
Ulcers				Autoimmune Disorder			
Fibromyalgia				Osteoporosis			
Chronic Fatigue				Cancer			
Eating Disorder				Other:			

FAMILY HISTORY: (heart, stroke, clotting defects, diabetes, osteoporosis, etc.)

FAMILY MEMBER	IMPORTANT DISEASES (list Cancer in table that follows)
Mother	
Father	
Brothers	
Sisters	
Aunt, paternal	
Uncle, paternal	
Grandmother, paternal	
Grandfather, paternal	
Aunt, maternal	
Uncle, maternal	
Grandmother, maternal	
Grandfather, maternal	

FAMILY MEMBER	TYPE OF CANCER	TREATMENT / OUTCOME

UROLOGICAL HISTORY

UROLOGIST _____

Date of last exam _____

Any problems in past or present _____

Top three biggest concerns / symptoms:

1. _____ Since When: _____

2. _____ Since When: _____

3. _____ Since When: _____

Please include any other medical or hormonal history that you think would be important.

SYMPTOMS I

Rate your current status for each symptom by checking the appropriate modifier.
Please feel free to use additional space to describe any symptoms.

	Absent	Mild	Moderate	Severe
Anxiety/Nervousness				
Decreased libido				
General Fatigue				
Depression				
Moodiness/Emotional				
Enlarged Prostate				
Urinary Problems				
Impotence				
Inability to Concentrate				
Rapid Increase in Weight				
Erectile Dysfunction				
Ejaculatory Problems				
Disturbed Sleep				
Loss of morning Erection				
Hair Loss of axilla/groin area				
Osteoporosis				

Consultation Notes:
