



NUTRITIONAL COMPOUNDING ORDER FORM FOR DOCTORS

DOCTOR'S DETAILS	
DATE	
DR'S NAME	
PRESCRIBER NO.	
DR'S PHONE	
DR'S FAX	

PATIENT DETAILS			
NAME			
PHONE NO.	(H)		
	(M)		
ADDRESS			
D.O.B.		WEIGHT	

AM Program	Strength
Vit C (Corn Free) (mg)	
B-6 (mg) <small>Script required for quantities exceeding 200mg of combined B-6 & P5P</small>	
P5P (mg) <small>Script required for quantities exceeding 200mg of combined B-6 & P5P</small>	
Vit E Succinate (IU)	
Vit E Syn soy-free (IU)	
Biotin (mcg)	
Cyanocobalamin (vitamin B-12) (mcg)	
Methylcobalamin (vitamin-B12) (mcg)	
Folic Acid (mcg)	
Folinic Acid (mcg)	
Niacinamide (mg)	
Chromium as Polynicotinate (mcg)	
Chromium as Picolinate (mcg)	
Methionine (mg)	
Calcium as Carbonate (mg)	
Calcium as Citrate (mg)	
Magnesium as Glycinate (mg)	
Magnesium as Oxide (mg)	
Vitamin A (IU) <small>Script required for quantities exceeding 10000IU</small>	
Beta Carotene (IU)	
Molybdenum (mcg)	
Selenium (mcg) as Selenomethionine <small>Script required for quantities exceeding 300mcg</small>	
Vitamin D (IU) <small>Script required for quantities exceeding 25mcg (1000IU)</small>	
Taurine (mg)	
Serine (mg)	
Ferrous Gluconate (mg)	
SAM-e (mg)	

PM Program	Strength
Vit C (Corn Free) (mg)	
Zinc as Picolinate (mg) <small>Script required for quantities exceeding 50mg</small>	
Manganese as Gluconate (mg)	
Vit E Succinate (IU)	
Vit E Syn soy-free (IU)	
Biotin (mcg)	
Cyanocobalamin (vitamin B-12) (mcg)	
Methylcobalamin (vitamin-B12) (mcg)	
Folic Acid (mcg)	
Folinic Acid (mcg)	
Niacinamide (mg)	
Chromium as Polynicotinate (mcg)	
Chromium as Picolinate (mcg)	
Methionine (mg)	
Calcium as Carbonate (mg)	
Calcium as Citrate (mg)	
Magnesium as Glycinate (mg)	
Magnesium as Oxide (mg)	
Vitamin A (IU) <small>Script required for quantities exceeding 10000IU</small>	
Beta Carotene (IU)	
Molybdenum (mcg)	
Selenium (mcg) as Selenomethionine <small>Script required for quantities exceeding 300mcg</small>	
Vitamin D (IU) <small>Script required for quantities exceeding 25mcg (1000IU)</small>	
Taurine (mg)	
Serine (mg)	
Ferrous Gluconate (mg)	
SAM-e (mg)	

Tick Appropriate box for AM / PM Program	
<input type="checkbox"/> Powder OR <input type="checkbox"/> Capsules <input type="checkbox"/> Tick if Patient has a soy allergy	Number of Days Supply (eg 100 days) _____ <i>Note to compounding Pharmacists: dispense as ELEMENTAL VALUE</i>

Payment Details	
<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Cheque/Money Order	
Cardholders Name: _____	
Card Number: _____ / _____ / _____ / _____	CVN: _____ <small>Located on back of card</small>
Expiry Date: ____ / ____	Signature: _____

Send Completed Order Form to Compounding Pharmacy:

Pharmacy: _____

Address: _____

Tel: _____ Fax: _____