



WILEY PROTOCOL®

Fax Order Form

Patient Name:		Date:
Address:		DOB:
City, State Zip:	Allergies:	
Phone:	Health Conditions:	

Wiley Face Crème

Women:

Wiley Protocol Estradiol (Circle One)
Original +2 +4 +6 Other _____

Wiley Protocol Progesterone (Circle One)
Original +2 +4 +6 Other _____

Wiley Protocol Testosterone (Circle One)
Original +2 +4 +6 Other _____

Wiley Protocol Thyroid (Circle One)
Original +2 +4 +6 Other _____

Calendar: Personal or Lunar

Start Date: _____

Men:

Wiley Protocol Testosterone (Circle One)
Original +2 +4 +6 Other _____

Wiley Protocol DHEA (Circle One)
Original +2 +4 +6 Other _____

Wiley Protocol Thyroid (Circle One)
Original +2 +4 +6 Other _____

Sig:

Use as directed as described by the Wiley Protocol.

Qty:

1 2 3 Months

Refills:

1 2 3 4 5 6 7 8 9 10 11 PRN

Authorizing Prescriber: (Please Print)

Signature:

Office Phone:

DEA: (required if prescribing Testosterone)

Notes:

Please Fax Completed Orders to (812) 944-6900

Westmoreland Pharmacy & Compounding, 2125 State St. #17, New Albany, IN 47150

Ph: (812) 944-6500 Toll-Free: 866-944-6505 Fx: (812) 944-6900

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