| Bio-Identical Hormone Replacement/ Medical Weight Loss Program |

KAYLA ADEBAJO NP-PHC

Personal Demographics

Name	Date of birth	Health Card #
Address	City State	Postal Code
Home phone	Work phone/Cell phone	Other Contact #
Email	Marital Status Married ☐ Single ☐ Other:	
Emergency Contact	Phone	
Employer	Position	Full-time Part-time Other:

Primary Care Physician

Name	Phone/Fax Number	
Address	City	Postal Code
PHARMACY INFORMATION:	Phone Number	Fax Number

Presenting Symptoms

Vital Signs: BP_______ T_____ P_____ R____

Wt. ________ Ht.__________ BMI _________

Are you satisfied with your weight and shape? ☐ **Yes** ☐**No** Your ideal weight is_________

Compared to an ideal weight, your current weight is:

☐More than 10lbs below ☐Within 10lbs + or - ☐11-20lbs over ☐ 21-40lbs over ☐ 41+ lbs over

How would you describe your body shape? (please circle)

Weight is evenly distributed ☐ Pear-Shaped (heavier in hips/lower body) ☐Apple-shaped (heavy in stomach/upper body)

Please briefly describe your symptoms relating to participating in the program at our clinic. Are you interested in weight loss, hormones or both?

Do you have a preferred route in which you would like to take your prescribed hormone therapy? *(Please note that certain routes may not be available—your practitioner will counsel you on best routes based on your medical history)*

☐ By mouth (under tonque, capsules or tablets) ☐ Through the skin in creams or patches
☐ Intramuscular injections or subcutaneous ☐ No preference ☐ Other___________

Patient Name:______________________________ DOB:__________ Date:________

Past Medical History

Please list any medical problems or illnesses you have had in the past or currently have. Include any hospitalizations and accidents with approximate dates.

Date	Medical diagnosis, illness, accident

Past Surgical History

Please list all surgeries in your past e.g. appendectomy, gallbladder removal, cosmetics.
Also please list any large tattoos or scars and list their locations.

Date	Surgery or Scar/Tattoo location

Specialists/Other Health Care Providers

Please list any current or previous specialists or health care providers you have consulted with in the past five years. E.G. Dermatologist, Allergist, Gastroenterologist, Cardiologists, Psychologists, Physiotherapy

SPECIALIST NAME	SPECIALTY	PURPOSE	CONTACT INFO (Location/#)

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Patient Name:_______________________________ **DOB:**__________ **Date:**________

Medications: Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins** that were used within **the past one year** if discontinued.

Name of Medication/Supplement	Dosage	Purpose/Dosing schedule

Family History

Please list ALL known family illness:
(e.g. heart disease, stroke, diabetes, blood clot history,hypertension)
Cancer history (e.g. breast, cervical, skin, prostate, lung, blood), etc.
If a member is deceased, please list age of death and cause if known.

Relationship	Age	Medical Problem(s)/ Cause of Death
Mother		
Father		
Brothers		
Sisters		
Spouse		
Children		
Grandparents		
Other Family		

Patient Name:______________________________ **DOB:**__________ **Date:**________

Social History

Please remember that this information is strictly confidential and will be used **only** to address your symptoms and/or complaints

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No

- If yes, how many packs per day? ___________
- How many total years have you smoked? ___________

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks and what type of alcohol (beer, wine, spirits etc.) do you have in an average week? ☐ None to 2 ☐ 3-7 ☐ 8-14 ☐ 15 or more drinks/week
  Types of alcohol____

Do you now or have you in the past used any recreational drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)? ☐ Yes ☐ No

- If yes, what substance(s) and how often? ____

  ____

Exercise/Activity Level

Do you participate in regular physical activity or exercise? ☐ Yes ☐ No

How many times/days per week do you exercise? _______________ How many minutes per day? ________

What activities do you engage in? (Please list all e.g. high interval training, aerobics, dance, walking, cross-fit)

____

Do you have activities or hobbies you wish to engage in, but have not as yet? Please tell us more:

____

Stress Experiences

In the past 12 months how often have you felt excessive stress in your life?
☐Never ☐Occasionally ☐ Often ☐ Almost Always

Have you had any recent life stressors in the past three years?
Please list or describe any recent life stressors in the past 1-3 years (divorce/marriage, change of address, difficult boss, new job):____
____

Do you have any history of traumatic events, violence, conflict, or living in an abusive environment?
If yes, when did these occur? (Please check all that apply).

☐Early childhood (age 0-12 years) ☐ Teenage/young adult (age 13-24 years) ☐ Adult (age25-44 years)

☐ Midlife (age 45-64 years) ☐ Older Adult (65+ years old)

Nutrition Practices

How many vegetable servings do you consume daily on average? (This does not include fruit servings).
A serving size is approximately the size of half your hand.

☐Hardly ever—I do not like veggies ☐1-2 servings ☐ 3-4 servings ☐ 4-8 servings ☐ 8+ servings

Patient Name:______________________________ **DOB:**__________ **Date:**________

<u>Nutrition Practices cont'd</u>

How many servings of water do you drink daily on average? (A serving is a cup/250ml or 8ozs)

☐Hardly ever—I do not like water ☐1-2 servings ☐ 3-4 servings ☐ 4-8 servings ☐ 8+ servings

In general, would you say your healthy nutritional intake is:
☐Excellent ☐Very Good ☐ Good ☐ Fair ☐Poor

<u>Sleep Practices (Please answer if sleep is an issue you would like addressed)</u>

I would rate my sleep quality as:
☐Excellent ☐Very Good ☐ Good ☐ Fair ☐Poor

How many hours of sleep on average do you get each night?
☐Less than 4 hours ☐4-6 hours ☐ 6-8 hours ☐ 8+ hours

On average, how long does it take to fall asleep?
☐I fall asleep right away ☐15-30 mins ☐ I lie awake for a long time, more than 1 hour

Do you experience night time awakenings? If yes, how many times on average do you wake up at night? *(Including having to get up to use the washroom)*
☐I sleep soundly all night ☐I toss and turn ☐ I'm up 1-2 times ☐ I'm up 2-3 times ☐ I'm up 3+ times

In the morning when you wake up, you feel…

☐Invigorated and ready to go ☐Most times feel refreshed
☐ Frustrated that your sleep is cut short, but your are able to get up and get going
☐ Like you haven't slept at all

Do you experience low energy/fatigue during the day? *(e.g. where you will need to get another coffee to function?)* Please describe when this typically occurs, what are your symptoms, and what you normally do to relieve your symptoms:

____

____

____

My biggest problem with sleep is… *(please check the **<u>MOST</u>** bothersome symptom)*
☐Falling asleep ☐Frequent waking up throughout the night ☐ Feeling unrefreshed in the morning

<u>Overall Health</u>

In general, would you say your overall health is:
☐Excellent ☐Very Good ☐ Good ☐ Fair ☐Poor

Patient Name:____________________________ DOB:__________ Date:________

Male Health History

Has a healthcare provider every diagnosed you with any of the following medical conditions? *(please circle Y-yes or N-no)*

Condition	
Benign prostatic hypertrophy	Y N
Prostate cancer	Y N
Testicular cancer	Y N
Any other type of cancer or blood disorder?	Y N
If yes, what type of cancer or blood disorder?	
Fibromyalgia	Y N
Osteoporosis or osteopenia	Y N
Thyroid disorder	Y N
Diabetes	Y N
Epilepsy/seizure disorder	Y N
Erectile Dysfuntion	Y N
High blood pressure	Y N
Liver disease	Y N
Gastrointestinal Absorption Disorder (GERDS/heartburn)	Y N

SYMPTOMS ASSESSMENT

Please review each category and mark which symptoms have been bothersome on a scale of 1 through 4. **1- no symptoms 2-minimal 3-moderately 4-severe**

Symptom	
Extreme Fatigue/tired or feeling exhausted	1 2 3 4
Urinary frequency	1 2 3 4
Lack of energy/endurance	1 2 3 4
Depression	1 2 3 4
Headaches and/or migraines	1 2 3 4
Rapid mood changes/mood swings	1 2 3 4
Lack of sex drive/libido/sexual desire	1 2 3 4
Difficulty having/maintaining erections	1 2 3 4
Hot flashes/night sweats	1 2 3 4
Bloating/water retention	1 2 3 4
Difficulty falling and staying asleep	1 2 3 4
Memory problems/forgetfulness	1 2 3 4
Acne/oily skin	1 2 3 4
Loss of body hair	1 2 3 4
Increased anxiety	1 2 3 4
Increased irritability and/or anger	1 2 3 4

How strong are your morning erections: ☐ Very hard and erect ☐ Somewhat hard and erect ☐ Not that hard ☐ I hardly have morning erections ☐ I do not have morning erections

Patient Name:______________________________ DOB:__________ Date:________

Female Health History

Gynecological History

Date of last PAP smear? ________________

Date of last mammogram? _________________ Results of mammogram:_____________

Date of last pelvic/abdominal ultrasound? _________________ Results of ultrasound:______________

	YES	NO
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have ______________________		
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have ______________________		
Have you ever had a breast biopsy?		
Have you ever had a cervical biopsy?		
Have you noticed breast skin or nipple changes, or lumps in your breast?		
Have you ever needed to do a breast ultrasound? If yes, what was the reason for the test? ____		
Have you in the past or are you using a birth control method? If yes, when and what kind? ____		
Are you still having menstrual periods? If yes, when was the **first day** of your **last menstrual period**? **LNMP:**________________________________		

Menstrual Period History

Please describe any problems you have with your periods, or used to have: e.g. cramps, spotting etc…
____

Periods are (were): ☐ regular ☐ irregular ☐ painful ☐ crampy ☐ heavy ☐ light ☐ other

Age periods began: _______ # days of bleeding _______ cycle length (days) _______

If you are no longer having periods, at what age did your periods stop? ___________________
If your periods stopped less than one year ago, how many months ago was your last period? ________
If you are now deemed menopausal, have you ever had any episodes of vaginal bleeding or spotting?
If yes, when did this occur and for how long? ____

Did your periods stop because you had a hysterectomy? ☐ Yes ☐ No

- If yes, what was the reason for the surgery? ______________________________
- Were the ovaries removed at the same time? ☐ Yes ☐ No ☐ Not Sure

Patient Name:______________________________ **DOB:**__________ **Date:**________

Female Health History

Cancer History ☐ (check if no to all)
Do you have a history of any of the following cancers or were you ever investigated for abnormalities in any of the following systems/anatomical sites:
☐ Thyroid ☐ Uterus ☐ Vagina/Vulva ☐ Cervix
☐ Ovarian ☐ Fallopian Tube ☐ Breast ☐ Colon
☐ Other: ____________________________________ ____________________________________

FEMALE SYMPTOMS ASSESSMENT

Please review each category and mark which symptoms have been bothersome by using the scale of 1 through 4. Please rate the level at which you experience the following symptoms. If your symptoms fall between numbers, choose the higher one.

Symptoms (Females only)	1 none	2 Minimal	3 Moderate	4 Severe
1. Fatigue/tired and or always exhausted				
2. Coffee/energy drink withdrawals				
3. Food cravings—carbs/salty/sweet				
4. Lack of energy or endurance				
5. Depression, feeling sad, low moods, tearful/crying				
6. Moodiness, rapid mood swings/mood changes				
7. Irritability or increased anger/hostility to others				
8. Increased anxiety or increased worrying				
9. Lack of sex drive/libido/sexual desire				
10. Vaginal dryness/irritation				
11. Pain with sex				
12. Breast tenderness, sore/swollen breasts, breast changes/lumps, or fibrocystic breast disease				
13. Bloating/water retention or swelling (edema)				
14. Headaches and/or migraines				
15. Forgetfulness/memory problems				
16. Brain Fog/Difficulty focusing/trouble thinking				
17. Acne or pimple skin problems				
18. Hair on face/chin—excessive hair on body				
19. Thinning hair or hair loss				
20. Weight gain or difficulty losing weight				
21. Loss of skin tone and/or increased wrinkles				

Patient Name:______________________________ DOB:__________ Date:________

Symptoms (Females only)	1 none	2 Minimal	3 Moderate	4 Severe
22. Increased skin injuries/thinner skin				
23. Muscle weaknesss and/or loss of strength				
24. Weight loss				
25. Brittle nails, cracked dry nails, nail changes				
26. Cold intolerance/wearing more clothing than others				
27. Heat intolerance—finding it's always too hot				
28. Dry skin				
29. Constipation				
30. Diarrhea/Loose stools				
31. Difficulty handling stress, freaking out at times				
32. Warm or flushed skin				
33. Nervousness, heart palpitations, pounding/irregular heartbeats				
34. Hand tremors/shakiness				
35. Excessive sweating				
36. Decreased motivation				
37. Decreased ability to be aroused/have orgasms or decreased sexual pleasure				
38. Difficulty falling or staying asleep, insomnia				
39. Snoring when asleep, sleep apnea				
40. Heavy and/or irregular periods				
41. Abdominal cramps				
42. Premenstrual disorder (symptoms days before menses)				
43. Breast less full and/or sagging				
44. Hot flashes/night sweats/nuclear meltdowns				
45. Low back pain or joint pain				
46. All over body aches and pain, chronic pain syndromes				

Have these symptoms occurred roughly at around the same time each month (cyclically)? ☐

Or have these symptoms occurred more randomly throughout the month? ☐

Patient Name:_____________________________ DOB:__________ Date:________

GENERAL HEALTH HISTORY (Male and Female)

System Review – Check the appropriate box for each question.

General Health Condition	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease? When?			
Do you have morning joint pain and stiffness lasting more than 30 minutes?			
Have you been diagnosed with any inflammatory/auto-immune conditions? If yes, which one(s):_______________________			
Do you suspect that you may have any inflammatory/auto-immune conditions? E.g. Lyme borealis disease, Lupus			
Do you suspect that you may have a health condition? If yes, which one?_____________________________			
Have you ever had extensive dental work? E.g. Root Canals			
Do you have any sensitivity to chemicals? Foods? Scents?			

Respiratory	Yes	No	Not Sure
Do you have a persistent cough?			
Do you have recurrent sinus infections?			
Do you have excessive daytime sleepiness?			
Do you snore? Y__ N__ Do you use a CPAP? Y__N__			
Have you had a previous sleep study? Was it abnormal?			
Have you ever been diagnosed with asthma, COPD or emphysema?			
Have you had respiratory infections in the past? E.g. pneumonia? When?_________________			

Cardiovascular	Yes	No	Not Sure
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have unexplained swelling in your feet or in your arms?			
Do you experience pain or swelling in your leg calves?			
Vascular disease or artery blockages/aneurysms?			
Aortic stenosis, heart valve issues, heart murmurs?			
Have you been diagnosed with any heart condition?			
Have you ever needed a stress test/cardiac test?			
Have you ever been diagnosed with a blood clot or a bleeding/platelet disorder?			
Have you ever had an issue with your cholesterol levels?			

Patient Name:______________________________ DOB:__________ Date:________

GENERAL HEALTH HISTORY (Male and Female)

Gastrointestinal	Yes	No	Not Sure
Do you have problems swallowing food? Choking symptoms?			
Do you have nausea or vomiting?			
Do you have diarrhea? Or constipation? (circle which one)			
Have you ever had blood in your stool?			
Do you have abdominal pain or bloating and gas?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine	**Yes**	**No**	**Not Sure**
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Do you have elevated blood sugar? Diabetes?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem or told you have a borderline thyroid disorder?			
Neurological	**Yes**	**No**	**Not Sure**
Do you sometimes have muscle weakness or difficulty walking?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Have you ever been diagnosed with any neuromuscular condition? E.g. multiple sclerosis, Parkinson's, tremors			
Do you have concerns of numbness or tingling in your extremities or hands/feet?			
Urologic / Renal	**Yes**	**No**	**Not Sure**
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others or than before?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems? E.g. cysts or stones?			
Musculoskeletal	**Yes**	**No**	**Not Sure**
Have you ever broken/fractured a bone? If yes, please provide the date and location of fractures___________			
Do you walk with a cane or a mobility aid?			
Have you been diagnosed with osteoporosis or osteopenia?			
Have you used progestins for a duration greater than 1 year? e.g. Depo-provera			
Have you ever been in a serious motor vehicle accident?			

Patient Name:______________________________ **DOB:**__________ **Date:**________

Disclosure / Liability Waiver

Within the medical community, there are opposing views with respect to the practice of integrative medicine, including the use of bio-identical hormonal replacement therapies bHRT. The use of bio-identical hormones is not recommended to be used to treat medical conditions. It is an off-label therapy used for symptoms of andropause, menopause, low energy, and mood symptoms. While numerous safety measures are taken by our health care providers and staff, incidental events may occur that are beyond the control of our staff.

For this, I____ understand that Integrative Therapies, including bio-identical hormone therapy does provide true medical benefit, and is being prescribed by Kayla Adebajo NP-PHC **to lessen or treat non-life threatening symptoms** you have identified as **bothersome, undesirable, and frankly unwanted**. You are aware that options include not treating your problematic symptom or having your own primary care provider/specialist prescribe your hormone therapy—which may not include naturally compounded bio-identical hormones. Your participation in this integrative medicine program, includes regimens that integrates the use of any medications, natural hormones, IV therapies and/or supplements. It is expressly agreed that this program is being undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal action against the program directors, treating provider or health care provider, and staff involved for injury to you on account of involvement in this Integrative Medicine and Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

Maintenance of Preventative Medicine and Cancer Surveillance

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer screening. It is recommended to have routine physical examinations which may include a PAP, mammogram, pelvic ultrasound for female. As well as PSA blood test and prostate testing for men. Other tests may need to be performed as indicated by your health conditions.

Your signature below indicates that you will comply by obtaining the these screening guidelines and as recommended from your primary care provider within 3 months of beginning the Bio-Identical Hormone Replacement Therapy Program and then according to current screening guidelines. This can be obtained, and followed with, your primary care provider. You also understand that all primary care services will be managed by your current primary care provider. At our Centre, we will only be managing symptoms related to hormone deficiency.

********I have read the above and all of my questions have been answered to my satisfaction. I attest that I have truthfully completed the health history intake form and have declared all of my known medical conditions. I accept all terms and conditions of this program and I am consenting to participate voluntarily in this program:**

Patient Name:____

Patient Signature: ________________________________ Date: ______________________

MD/NP Signature: ________________________________ Date: ______________________

Patient Name:_____________________________ DOB:__________ Date:________

Integrative Medicine--NEW PATIENT CONSENT FORM FOR PATIENTS 2017

1) This form is to specify my consent for treatment with a combination of Integrative Medicine, Bio-identical (BHRT), Testosterone Replacement (TRT), Human Chorionic Gonadotrophin (HCG), and Human Growth Hormone (HGH). I understand separate consent forms and screening forms may be needed. **(pt initials _____)**

2) TREATMENT - BHRT and TRT - I understand that the Nurse Practitioner (NP) will suggest custom compounded prescriptions and supplements/vitamins for the patient (both are an extra cost) as part of Integrative Medicine. I understand some supplements such as DIM (which improves Estrogen metabolism) and tests such as the DUTCH urine test are recommended as treatment in the bHRT program. **(patients initials _____)**

3) BENEFITS OF BHRT & TRT . _I consent that the clinic staff/RN/NP/MD has discussed with me the potential benefits and associated risks of taking or not taking Integrative Medicine, BHRT & TRT. **(pt initials ________)**

4) PATIENT'S CONSENT - I have read and fully understand this consent form and realize my BHRT, TRT, Treatment, Rx/Prescriptions, Supplements & Vitamins and all clinician time for consultations, plus any future consultations are all fee based and are not covered by OHIP or insurance. I agree to pay the fee at the time of my consultation unless I have paid the annual fee up front. **(patients initials ________)**

5) CONSENT TO TELEMEDICINE- I understand that the healthcare provider/clinician will conduct scheduled follow-ups and medical assessments with me through the use of a telemedicine conference platform. Such as with OTN or Skype calling and which includes a video presence**. (patients initials ________)**

6) LAB TEST NOTE: I understand that the majority of the Hormone Blood Lab Test panel is under OHIP coverage where applicable. I understand some tests are not insured under OHIP. –Saliva are fee based and non-OHIP covered. (blood serum is our preferred testing method) **(patients initials ________)**

7) CANCELLATION/RESCHEDULING FEES: Re: Initial Comprehensive Interview: I understand that there is a $150 cancellation fee for cancellations of the Initial Interview made less than a 72hrs period (3 day notice). Cancellations made any other time are subject to a $75 fee. **(patients initials ________)**

Re: Follow-up appointments. I also understand that there is a $75 cancellation fee for cancellations made less than a 72hr notice period (3 day notice). And $50 cancellation fee at any other time. **(patients initials _______)**

BHRT FEE's: As discussed the cost of my fees are: $_________ (Initial Year) and/or $_________ per___months/consultation.
1-. ALL FIRST CONSULTATIONS ARE PAID AT THE TIME OF FIRST BOOKING BY CREDIT CARD.
2.- The BHRT Block fee for 1 year annually is paid in full at time of booking (no payments)
The consultations services are NOT covered by OHIP or by insurance - I agree to pay by cash or credit card at the time of my visit to the clinic. (We do NOT accept cheques. We do NOT invoice or bill patients)

INSURANCE: Patients may submit their own Rx/prescription receipt(s) to their insurance provider on their own accord.

I give my consent to the administration of the above named BHRT treatment, bioidentical testosterone therapy, integrative medicine and lab tests as needed.

PLEASE PRINT CLEARLY

PATIENT'S NAME (print please) ____

PATIENT'S SIGNATURE FOR CONSENT __________________________________ **DATE**________________

WITNESS NAME/POSITION: _____________________________ **WITNESS SIGNATURE:** ________________

Patient Name:____________________________ DOB:__________ Date:________

Checklist of Files to be submitted to NP

***Please fax the requested files below in the checklist that pertain to you.
If you have completed any medical tests in the past or have specialist consults that may be pertinent to your health history, please submit these previous records.

Please check if included in fax	CHECKLIST
	PHOTOCOPY OF ONTARIO HEALTH CARD
	If DHEA or Testosterone prescribed—require 2nd photocopy of Government ID E.G. Driver's License, Passport
	COMPLETED INTAKE FORM AND CONSENT FORMS
	COMPLETED LABORATORY DOCUMENT—within the past 3 months. Labs must also be completed after Intake. *****Please book appointment with NP 2 weeks after labs completed by patient**
	PATIENTS ON THYROID
	A THYROID ULTRASOUND MAY BE REQUESTED IF YOU HAVE ABNORMAL THYROID LABS or THYROID NODULES—this is required within **3 months** of starting thyroid therapy as a baseline. A repeat ultrasound will be requested based on NP assessment
	WOMEN (50 AND UNDER)
	PELVIC/TRANSVAGINAL ULTRASOUND – Taken in the last 12 months and done every 2-3 years unless high risk.
	PAP SMEAR - Completed in the past 3 years. PAPs are voided in women without a cervix.
	BREAST ULTRASOUND- For women with a high risk for breast cancer or has breast cancer/suspicious lump history she will also need yearly ultrasounds
	WOMEN (50 AND OVER)
	MAMMOGRAM taken in the last 12 months. *****Estrogen will not be prescribed without this information.** **Other options:** A woman can provide a MRI result to replace the mammogram. As well as a thermography report accompanied with a recent breast ultrasound. Or Please have patient submit a signed attestation of their refusal to submit diagnostic evidence (e.g. mammogram or MRI) that proves they are breast cancer free while undergoing estrogen therapy.

Patient Name:_____________________________ **DOB:**__________ **Date:**________

Please check if included in fax	CHECKLIST
	PELVIC/TRANSVAGINAL ULTRASOUND – Taken in the last 12 months and done every 2-3 years unless high risk. **This data is necessary if there is a history of spotting in menopause years. Endometrial biopsy report may also be requested.
	PAP SMEAR - Completed in the past 3 years. PAPs are voided in women without a cervix.
	WOMEN (65 AND OVER)
	BONE MINERAL DENSITY TEST—in addition to the requested tests for women over 50 years old.. If you have completed this in the past, please submit previous records. One BMD is required as a baseline within 1 year of starting bHRT
	MEN (50 AND UNDER)
	PSA TESTING—a baseline PSA test will be required and is typically not covered by OHIP
	MEN (50 AND OVER)
	PSA TESTING—a baseline PSA test will be required and is typically not covered by OHIP
	TRANSRECTAL ULTRASOUND—this may be requested. Please submit previous records if you have completed this ultrasound in the past.
	BONE MINERAL DENSITY TEST—will only be requested if you are at high risk for fractures. If you have completed this in the past, please submit previous records.
	BASELINE AND MONITORING TESTS
	A baseline symptoms score is required, as well at follow-up for both men and women. This tracks progress with your symptoms you identify as bothersome and unwanted.
	NON-OHIP TESTS (OPTIONAL)
	The majority of tests that will be ordered will be covered by OHIP (if you have this type of insurance). There are a few tests that are not covered and include additional fees. These tests provide valuable information and enhance the ability to prescribe the most suitable therapeutics for your health concern. However, the payment for these tests are optional. **You will be explained the purpose for the NON-OHIP test and will ultimately make the decision if the suggested test is right for you.**