THE MENOPAUSE & WELLBEING CLINIC

PRESCRIPTION RENEWAL REQUEST

ELIGIBILITY REQUIREMENTS

BEFORE COMPLETING THIS FORM, PLEASE CONFIRM THAT:

☐ YOU ARE AN EXISTING PATIENT OF THE MENOPAUSE AND WELLBEING CLINIC.

☐ YOU HAVE BEEN SEEN BY DR. CASEY BYE WITHIN THE LAST 12 MONTHS.

☐ YOUR BREAST SCREENING (MAMMOGRAM, ULTRASOUND OR MRI) IS UP TO DATE.

IF YOU DO NOT MEET THESE REQUIREMENTS, OR IF YOU HAVE NEW SYMPTOMS OR CONCERNS, WE WILL REQUEST THAT YOU BOOK A FACE-TO-FACE CONSULTATION INSTEAD.

PATIENT DETAILS

- FULL NAME: _____
- DATE OF BIRTH: ____ / ____ / _____
- EMAIL: _____
- PHONE: _____

BREAST SCREENING DETAILS

- DATE OF MOST RECENT BREAST IMAGING: ____ / ____ / _____
- WHERE PERFORMED: ☐ BREASTSCREEN ☐ LUMUS ☐ MRI ☐ OTHER:

MEDICATION RENEWAL REQUEST

PLEASE TICK THE MEDICATIONS YOU ARE REQUESTING AND PROVIDE YOUR CURRENT DOSE.

☐ ESTROGEL - NUMBER OF PUMPS: _____

☐ PROMETRIUM

- ☐ CYCLICAL (2 CAPSULES DAYS 15-26)
- ☐ CONTINUOUS (1CAPSULE EVERY NIGHT)

ANDROFEME 1% CREAM - ☐ 0.5ML; ☐ 0.75ML; ☐ 1ML

(YOUR TESTOSTERONE BLOOD LEVEL MUST BEEN CHECKED WITHIN THE LAST 6 MONTHS)

VAGINAL OESTROGEN

- ☐ OVESTIN CREAM
- ☐ OVESTIN PESSARIES
- ☐ INTRAROSA PESSARIES

ADDITIONAL
COMMENTS:_____

FINANCIAL CONSENT

☐ I UNDERSTAND THAT A FEE OF $50 IS PAYABLE BEFORE THE PRESCRIPTION IS ISSUED.

PLEASE FORWARD COMPLETED FORM TO
RECEPTION@LCMC.COM.AU