



## Welcome to Rushmore Compounding Pharmacy!

Thank you for choosing us to help you with your hormone replacement therapy journey.

Please take a few minutes to read this information sheet. It will answer the most frequently asked questions and explain the process of testing your hormones. If you have any further questions, please feel free to contact us.

- All hormones require a prescription. If you have a current provider, we can work with them. If you do not have a provider, please reach out to us as we do have a provider list.
- The next step is to complete a ZRT kit. These are free from our pharmacy, and you pay ZRT directly for your labs. After ZRT processes the labs, they are sent to us to review.
  - Types of ZRT kits
    - Saliva kits are preferred for most patients, for sex hormones (e.g. estradiol, progesterone, DHEA, and testosterone) and cortisol levels.
    - Blood spot kits are also available for patients who cannot produce enough saliva. If patients are using a topical hormone cream, contamination can occur resulting in inaccurate labs. This kit is not recommended for patients interested in cortisol levels, who experience fatigue, trouble sleeping, high stress, or burnout symptoms.
  - Each kit has full instructions on collection and mailing. **For the most information, we recommend S-142 | LCMS Hormones 7 with 4-point cortisol.** This includes sex hormone testing and an adrenal profile (DHEA and cortisol).
  - Please speak with the pharmacist if you are currently a smoker, as hormones may not be indicated.
- In addition to a ZRT kit, **each patient will fill out a questionnaire. This should be returned to us before your consultation as we will use this information**, along with your labs, to make recommendations to your provider. **Please do not send it in with your labs, ZRT will dispose of it.** The questionnaire can be scanned and emailed, mailed or faxed back to us.
- When we receive your test results, we will call you to schedule a consultation with a pharmacist. These are done over the phone, and the consult fee is \$75. The pharmacist will discuss prescription and over the counter options, and send a recommendation to your provider, if appropriate. Pending approval from your provider, we will call you when your prescription is ready for pickup. Please note that these medications are compounded specifically for you and can take 2-3 business days for us to make. We also do not contract with any insurance companies, so the cost of each prescription is an out-of-pocket expense. We can supply you with a reimbursement form that you can submit to your insurance company.



1308 MT. RUSHMORE RD  
RAPID CITY, SD 57701  
PHONE: 605-721-0831

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

**Doctor we should contact for this therapy:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Do you use tobacco? \_\_\_ yes \*\* \_\_\_ no \*\*Please note that hormones may not be recommended  
Do you use alcohol? \_\_\_ yes \_\_\_ no  
Do you use caffeine? \_\_\_ yes \_\_\_ no

How often and how much?

**Allergies:** Please list all that apply.

Drugs: \_\_\_\_\_

Foods: \_\_\_\_\_

Other: \_\_\_\_\_

Please describe the allergic reaction and when it occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all over the Over-The-Counter (OTC) items you currently or occasionally use, such as antacids, pain relievers, acid blockers, laxatives, antihistamines, decongestants, cough suppressants, anti-diarrheals, sleep aids, etc. (NOT INCLUDING NUTRITIONAL SUPPLEMENTS):

\_\_\_\_\_

**Medical Conditions/Diseases:** Please check all that apply to you.

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Heart disease            | <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> Thyroid disease          | <input type="checkbox"/> Hormonal related issues     | <input type="checkbox"/> Lung condition         |
| <input type="checkbox"/> Blood clotting problems  | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Arthritis or joint problems | <input type="checkbox"/> Depression             |
| <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Headaches/Migraines      | <input type="checkbox"/> Eye disease                 | <input type="checkbox"/> Bipolar Disorder       |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Lyme Disease             | <input type="checkbox"/> Schizophrenia               | <input type="checkbox"/> Infection: please list |
| <input type="checkbox"/> Parkinson's Disease      | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Traumatic Brain Injury      | <input type="checkbox"/> Other please list      |

\_\_\_\_\_



**How frequently do you have a bowel movement?** \_\_\_\_\_

**Is this a change from normal frequency?** \_\_\_\_\_

**How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy (BHRT)?**

Doctor \_\_\_ Self \_\_\_ Friend/Family Member \_\_\_ Other \_\_\_\_\_

**What are your goals with BHRT or natural hormone replacement use?**

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**Please write down any questions you have about BHRT?**

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**How would you describe your stress level?**

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**Do you Exercise?      YES      NO**

**If yes describe what type and how often:**

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**Patient Name:** \_\_\_\_\_

## Symptom Survey

Instructions: Please enter the appropriate response number to each question in the columns below.

**0 = None/ Absent    1 = Mild or Rare    2 = Moderate    3 = Severe**

Add an \* (asterisk) if symptom is intermittent or "comes & goes".

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hot flashes             | <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Acne                          |
| <input type="checkbox"/> Night sweats            | <input type="checkbox"/> Irritability              | <input type="checkbox"/> Increased facial or body hair |
| <input type="checkbox"/> Vaginal Dryness         | <input type="checkbox"/> Nervousness               | <input type="checkbox"/> Scalp hair loss               |
| <input type="checkbox"/> Incontinence            | <input type="checkbox"/> Fibromyalgia              | <input type="checkbox"/> Weight gain in the hips       |
| <input type="checkbox"/> Bleeding changes        | <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Weight gain in the waist      |
| <input type="checkbox"/> Uterine fibroids        | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> High Cholesterol              |
| <input type="checkbox"/> Water retention         | <input type="checkbox"/> Sugar cravings            | <input type="checkbox"/> Elevated triglycerides        |
| <input type="checkbox"/> Tender Breast           | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Decreased Libido              |
| <input type="checkbox"/> Fibrocystic Breast      | <input type="checkbox"/> Cold body temperature     | <input type="checkbox"/> Decreased muscle size         |
| <input type="checkbox"/> Increased Forgetfulness | <input type="checkbox"/> Goiter                    | <input type="checkbox"/> Thinning skin                 |
| <input type="checkbox"/> Foggy Thinking          | <input type="checkbox"/> Hoarseness                | <input type="checkbox"/> Ringing in the ears           |
| <input type="checkbox"/> Tearful                 | <input type="checkbox"/> Dry or brittle hair       | <input type="checkbox"/> Rapid Aging                   |
| <input type="checkbox"/> Depressed               | <input type="checkbox"/> Brittle or breaking nails | <input type="checkbox"/> Aches and Pains               |
| <input type="checkbox"/> Mood Swings             | <input type="checkbox"/> Constipation              | <input type="checkbox"/> Bone Loss                     |
| <input type="checkbox"/> Stress                  | <input type="checkbox"/> Slow pulse rate           | <input type="checkbox"/> Panic Attacks                 |
| <input type="checkbox"/> Morning fatigue         | <input type="checkbox"/> Rapid heartbeat           | <input type="checkbox"/> ADD/ADHD                      |
| <input type="checkbox"/> Evening fatigue         | <input type="checkbox"/> Heart Palpitations        | <input type="checkbox"/> Compulsions/Addictions        |
| <input type="checkbox"/> Difficulty sleeping     | <input type="checkbox"/> Infertility problems      |  |
| <input type="checkbox"/> Decreased stamina       | Other: _____                                       |  |

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How old are you? \_\_\_\_\_

How old do you feel? \_\_\_\_\_

Patient Name \_\_\_\_\_