SMP Fertility

F: 866.301.1364
P: 855.255.5005

Donor ID/ Name: _____

Donor D.O.B: _____ Allergies: _____

☐ IVF ☐ ICSI ☐ IUI
☐ REC ☐ DON ☐ CRYO

Ship to: ☐ Office ☐ Patient Phone #: _____ Email: _____

For Payment /Recipient Name: _____ D.OB: _____ Phone #: _____

☐ Gonal F ☐ 300IU Pen ☐ 450IU Pen ☐ 900IU Pen
☐ 75IU ☐ 450IU M-D ☐ 1050IU M-D
Sig. _____ _____ Vials _____ Refills

☐ Follistim AQ ☐ 300IU ☐ 600IU ☐ 900IU
Sig. _____ _____ Car. _____ Refills

☐ Follistim Pen (if cart. ordered) _____ # _____ Refills

☐ Menopur 75IU vial
Sig. _____ _____ Vials _____ Refills

☐ Cetrotide ☐ 0.25mg ☐ 3mg
Sig. _____ _____ Vials _____ Refills

☐ Ganirelix Acetate (Antagon) 250ug/0.5ml
Sig. _____ _____ Syr. _____ Refills

☐ Leuprolide 2 week kit

☐ Extra Lupron syringes
Sig. _____ _____ Kits _____ Refills

☐ Lupron Microdose (cmpd)
__40__ mcg/__0.2__ml __10__ml Vial
Sig. _____ _____ Vials/Syr. _____ Refills

☐ Lupron Trigger PFS (cmpd) ☐ 2mg/0.4ml ☐ 4mg/0.8ml
Sig. _____ _____ Syr. _____ Refills

☐ Pregnyl 10,000IU ☐ Novarel 10,000IU vial
Sig. _____ _____ Vials _____ Refills

☐ Ovidrel 250mg PFS
Sig. _____ _____ PFS _____ Refills

☐ Saizen ☐ 5mg ☐ 8.8mg
Sig. _____ _____ Vials _____ Refills

Sig. _____ _____ Qty _____ Refills

☐ Synera Patches / Topical Patch

Sig. _____ _____ Box _____ Refills

Sig. _____ _____ Qty _____ Refills

Sig. _____ _____ Qty _____ Refills

☐ Progesterone in Oil ☐ 50mg ☐ 100mg/ml 10ml vial
☐ Sesame Oil ☐ Ethyl Oleate
Sig. _____ _____ Vials _____ Refills

☐ Progesterone Vaginal Suppositories (cmpd)
☐ 50mg ☐ 100mg ☐ 200mg
Sig. _____ _____ Supp. _____ Refills

☐ Progesterone Micronized Vaginal Capsules 200mg (cmpd)
Sig. _____ _____ Caps. _____ Refills

☐ Crinone 8% gel (15 apps./box)
Sig. _____ _____ Apps _____ Refills

☐ Endometrin 100mg
Sig. _____ _____ Boxes _____ Refills

☐ Baby Aspirin 81mg
Sig. _____ _____ Tabs _____ Refills

☐ Clomiphene Citrate 50mg
Sig. _____ _____ Tabs _____ Refills

☐ Doxycycline 100mg
Sig. _____ _____ Caps _____ Refills

☐ Estrace ☐ 1mg ☐ 2mg
Sig. _____ _____ Tabs _____ Refills

☐ Medrol ☐ 4mg ☐ 16mg
Sig. _____ _____ Tabs _____ Refills

☐ Provera Tabs 10mg
Sig. _____ _____ Tabs _____ Refills

☐ **Vivelle dot** / Miniville ☐ 0.1mg ☐ 0.05mg
Sig. _____ _____ Patches _____ Refills

☐ Zithromax 250mg
Sig. _____ _____ Tabs _____ Refills

☐ Lovenox 40mg PFS
Sig. _____ _____ Syr. _____ Refills

☐ Dostinex (Cabergoline) 0.5mg
Sig. _____ _____ Tabs _____ Refills

☐ Heparin ☐ 5,000 units/ml
Sig. _____ _____ Vials _____ Refills

☐ Des ogen 28 day
Sig. _____ _____ Pk _____ Refills

Sig. _____ _____ Qty _____ Refills

☐ Sharps Package – (Sterile sponges, alcohol swabs, sharps container)
☐ 3ml syringe _____ # _____ Refills
☐ 18g 1 ½" 3cc syringe and needle _____ # _____ Refills
☐ 30g ½" needle _____ # _____ Refills
☐ 25g 5/8" needle _____ # _____ Refills
☐ 27g ½" needle _____ # _____ Refills
☐ 22g 1 ½" needle _____ # _____ Refills
☐ _____ _____# _____ Refills

Submitted By: _____

Anticipated Start Date: _____ /_____ /_____ Today's Date: _____ /_____ /_____

Physician's Signature: _____, MD

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space