Dear Patient,

You've made the right choice towards truly living your life again! At Carolina Hormone and Health Center, we understand the struggle of life changing due to peri-menopause, menopause and andropause. Over the last 12 years, we have helped thousands of patients just like you address this change, and the first step is your complimentary consultation. We will discuss your symptoms and medical history to help you understand if Bioidentical Hormone Replacement Therapy is the right choice for you.

Inside this packet, we have enclosed several pages for you to fill out as well as some of our company's policies. Please take the time to read through this packet and answer the questions as completely as possible. Pay particular attention to the Menopausal Rating Scale & Andropausal Rating Scale, or "Symptom Sheet", as it is important that we understand the symptoms you may be experiencing and to what degree so that we can approach your individual treatment plan accordingly.

What to bring with you to your appointment:

- ☐ New Patient Paperwork
- ☐ Consent for Use & Disclosure of Information Form
- ☐ Signed Cancellation / No Show Policy
- ☐ Copy of Most Recent Mammogram
- ☐ Copy of Most Recent Pap

Things to remember:

- Please arrive 10-15 minutes early to your appointment.
- We do not accept Medicare or Medicaid.
- We offer additional services to help you reach your optimal health, including aesthetics.

We are committed to making sure your treatment and visits with us are as positive as they can be. We understand that you are a unique individual and we strive to provide you with the highest quality medical care while educating you on our customized approach of treatment. Our primary concern is to restore you to a state of "well-being" and optimized health. Our patients are treated with compassion and respect, and we encourage you to openly express your needs and concerns to our staff.

We look forward to seeing you soon!

300 West Coleman Blvd. Ste 101 Mt Pleasant, SC 29464
(843) 606-2530 | Fax: (843) 606-2596

3231 Sunset Blvd. Ste C West Columbia, SC 29169
(803) 454-8500 | Fax: (803) 454-8505

CAROLINA HORMONE & HEALTH CENTER
THE RETREAT AT CHHC
Life is meant for living, not just existing.

NEW PATIENT PAPERWORK

Contact Information

Name: _____ Date: _____
Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Phone # -Home: _____ Cell #: _____
Work #: _____ Employer: _____
Where/When are the best times to reach you? _____
SSN: _____-_____-_____ Driver's License #: _____
May we send text messages regarding appointments to your cell #? ☐ Yes ☐ No

Name of Physician: _____ Phone #: _____
Date of Last Physical Exam: _____ Purpose: _____
Preferred Retail Pharmacy: _____ Phone #: _____
Preferred Compounding Pharmacy: _____ Phone #: _____

Insurance Information

Primary Insurance Company: _____ ID#: _____
Policy Holder Name: _____ DOB: _____

Secondary Insurance Company: _____ ID#: _____
Policy Holder Name: _____ DOB: _____

Marital Information

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower
Spouse/Partner's Name: _____ DOB: _____
Spouse/Partner's Phone #: _____

In Case of Emergency

Emergency Contact: _____ Phone #: _____
Relationship to Patient: _____
Address: _____ City: _____ State: _____

How did you hear about Carolina Hormone and Health Center or who may we thank for referring you? _____

Other family members seen by us? _____

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MEDICAL HISTORY

Patient Name: _____ DOB: _____

Age: _____Height: _____ Weight: _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check (✓) if you have ever had the following:

Yes	No	
☐	☐	Hospitalization for illness or injury: (Please explain)_____ _____
☐	☐	Heart Attack _____
☐	☐	Heart Murmur _____
☐	☐	Rheumatic Fever _____
☐	☐	Mitral Valve Prolapse _____
☐	☐	Scarlet Fever _____
☐	☐	High Blood Pressure _____
☐	☐	Low Blood Pressure _____
☐	☐	Stroke _____
☐	☐	Artificial Prosthesis (i.e. heart valve or joints) _____
☐	☐	Anemia or Other Blood Disorder _____
☐	☐	Prolonged Bleeding / Hemophilia _____
☐	☐	Emphysema _____
☐	☐	Tuberculosis _____
☐	☐	Asthma, COPD, or Lung Disease _____
☐	☐	Sinus Problems _____
☐	☐	Kidney Disease _____
☐	☐	Liver Disease or Hepatitis (Type _____)
☐	☐	High Cholesterol _____
☐	☐	Diabetes _____ Treatment: ☐ Insulin ☐ Oral Medication ☐ Diet Last HBA1C Test Date: _____ Result: _____
☐	☐	Blood Clots in Legs or Lungs _____
☐	☐	Chronic Bronchitis _____
☐	☐	Leukemia _____
☐	☐	Lymphoma _____
☐	☐	Colon Cancer _____
☐	☐	Colon Polyps _____
☐	☐	Stomach or Duodenal Ulcer _____
☐	☐	Digestive Disorders (Colitis, IBS, Reflux, Diverticulitis) _____
☐	☐	Arthritis or Other Bone, Joint, or Muscle Disease _____
☐	☐	Osteopenia _____
☐	☐	Osteoporosis _____

Yes	No	
☐	☐	Epilepsy, Convulsions, Seizures _____
☐	☐	Water Retention / Swelling / Bloating
☐	☐	Neurological Problems _____
☐	☐	Viral Infections, Cold Sores _____
☐	☐	Keloids _____
☐	☐	Hives, Skin Rash, Hay Fever _____
☐	☐	Acne Prone Skin _____
☐	☐	Sensitivities to Adhesives _____
☐	☐	Issues with Local Anesthesia _____
		Allergic reaction to:
☐	☐	Aspirin, Ibuprofen, Acetaminophen
☐	☐	Penicillin
☐	☐	Erythromycin
☐	☐	Tetracycline
☐	☐	Codeine
☐	☐	Local Anesthetic
☐	☐	Nuts
☐	☐	Latex
☐	☐	Other _____
☐	☐	HIV / Aids _____
☐	☐	MRSA / Staph _____
☐	☐	Tumor, Abnormal Growth _____
☐	☐	Blood Transfusion _____
☐	☐	Emotional Problems _____
☐	☐	Psychiatric Disorder _____
☐	☐	Depression _____
☐	☐	Alcohol / Drug Dependency _____
☐	☐	Sleep Apnea _____
☐	☐	Recent Weight Loss/Gain _____
☐	☐	Fear of Needles _____
☐	☐	Stress Headaches / Tension Headaches / Migraines
☐	☐	Clenching / Grinding Teeth or TMJ
☐	☐	Thyroid Disease / Thyroid Problems ☐ Low Function ☐ Overactive ☐ Goiter ☐ Hashimotos
☐	☐	Rheumatoid Arthritis _____
☐	☐	Inflammatory Bowel Disease _____
☐	☐	Psoriasis _____
☐	☐	Multiple Sclerosis _____
☐	☐	Other Autoimmune _____

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MEDICAL HISTORY (CONT.)

Patient Name: _____ DOB: _____

Do you have a family history of any of the above? _____

_____

_____

_____

Any other medical diagnosis or condition(s)? _____

_____

Please list all allergies: _____

_____

Please list all medications you are currently taking, including OTC's, supplements & vitamins.

Name	Purpose	Name	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you currently using any form of Testosterone or Hormone Therapy? ☐ Yes ☐ No

If yes, please check (✓) which type:

☐ Cream ☐ Gel ☐ Pills ☐ Patches ☐ Injections ☐ Pellets ☐ Other _____

Please list any form of Testosterone or Hormone Therapy you have used in the past year: _____

_____

Please feel free to provide us with any other information you feel is pertinent to your medical history. The more information we have, the better we are able to assist you with your present symptoms. _____

_____

_____

_____

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MENOPAUSAL RATING SCALE / FEMALE SYMPTOMS

Please rate symptoms 0-3: 0=none, 1=mild, 2=moderate, 3=severe

Patient Name: _____ DOB: _____

Comments, if any:

(P)

Sleep Disturbances 0 1 2 3 _____

(difficulty falling asleep, sleeping through the night, waking early)

Depression 0 1 2 3 _____

(feeling sad, down, on the verge of tears, lack of drive, mood swings)

Irritability 0 1 2 3 _____

(feeling nervous, inner tension, aggression)

Anxiety 0 1 2 3 _____

(restlessness, feeling panicky)

(E)

Vaginal Dryness 0 1 2 3 _____

(sensation of dryness or burning, difficulty with sexual intercourse)

Hot Flashes / Night Sweats 0 1 2 3 _____

(episodes of sweating, flushing of face and neck)

Palpitations 0 1 2 3 _____

(heart skipping, racing, tightness)

Hair Loss / Shedding 0 1 2 3 _____

(T)

Energy Level 0 1 2 3 _____

(general decrease in performance)

Focus 0 1 2 3 _____

(impaired memory, decrease in concentration, forgetfulness)

Sexual Function 0 1 2 3 _____

(change in sexual desire, sexual activity, and satisfaction)

Body/Joint Pains 0 1 2 3 _____

(pain in joints, muscular discomfort, rheumatoid complaints)

Physical Activity/Stamina 0 1 2 3 _____

(extreme tiredness during/after physical activity)

Weight Concerns 0 1 2 3 _____

(please list concerns)

(Sexual Health)

Painful Intercourse 0 1 2 3 _____

Stress Urinary Incontinence 0 1 2 3 _____

(loss of urine when laughing, sneezing, or coughing)

FOR OFFICE USE ONLY

Dose/Recommendation:

Nurse/MA Initials: _____

OBGYN HISTORY

Patient Name: _____ DOB: _____

Please check (✓) any of the following that apply:

- ☐ I have completed my family.
- ☐ I am married.
- ☐ I am sexually active.
- ☐ I want to be sexually active.
- ☐ I do not want to be sexually active.
- ☐ I have a history of using steroids for exercise performance.
- ☐ My sex life has suffered.
- ☐ I have not been able to have an orgasm or it is really difficult.

What type of contraception are you using, if any? ☐ Pills ☐ Tubal Ligation ☐ Condoms ☐ IUD ☐ Withdrawal ☐ Depo-Provera ☐ Vasectomy ☐ Implants ☐ Other _____

Are you having problems with your birth control? ☐ Yes ☐ No

Have you ever had any vaginal, cervical and/or tubal infection? ☐ Yes ☐ No

If **yes**, please check (✓) any of the following that apply:

☐ Gardnerella ☐ Syphillis ☐ Codyloma ☐ Bacterial Vaginitis ☐ Yeast ☐ PID
☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Warts ☐ Other _____

Date of last pap smear: _____

Have you had an abnormal pap smear? ☐ Yes ☐ No

If **yes**, how was it treated? Please check (✓) any of the following that apply:

☐ Repeated Pap Smear ☐ Colposcopy ☐ Laser Surgery ☐ Cone Biopsy
☐ Cryosurgery (freezing) ☐ Hysterectomy ☐ Loop Excision

Are you pregnant? ☐ Yes ☐ No

Are you planning to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

How many times have you been pregnant? _____

How many miscarriages have you had? _____

Have you had any premature deliveries? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No

Do you have trouble leaking urine? ☐ Yes ☐ No

Do you use a panty liner or a pad? ☐ Yes ☐ No

Do you wake up at night to urinate? ☐ Yes ☐ No If **yes**, how often? _____

Have you ever had a urinary tract infection? ☐ Yes ☐ No

Have you ever had Venereal Disease? ☐ Yes ☐ No

Do you have any breast lumps, tenderness, or discharge? ☐ Yes ☐ No

Have you had a mammogram? ☐ Yes ☐ No Date: _____

Was it normal? ☐ Yes ☐ No Who performed it? _____

Do you do self breast exams? ☐ Yes ☐ No

Do you have any uterine abnormality? ☐ Yes ☐ No

Do you have a history of infertility? ☐ Yes ☐ No

Have you had abnormal bleeding in the past year? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever had a yeast infection? ☐ Yes ☐ No

Have you ever had lichen sclerosis? ☐ Yes ☐ No

OBGYN HISTORY (CONT.)

Patient Name: _____ DOB: _____

Have you ever had breast cancer? ☐ Yes ☐ No

If yes, please check (✓) type of treatment:

☐ Lumpectomy ☐ Mastectomy ☐ Radiation Therapy ☐ Chemotherapy

Date of Last Treatment: _____

Have you ever had cervical cancer? ☐ Yes ☐ No

If yes, how was it treated? _____

Have you ever had uterine cancer? ☐ Yes ☐ No

If yes, how was it treated? _____

Please check (✓) if you have had surgery for any of the following:

☐ Breast Cancer
☐ Uterine Cancer
☐ Ovarian Cancer
☐ PCOS
☐ Excess Facial / Body Hair
☐ Endometriosis
☐ Fibrocystic Breast or Breast Pain
☐ Uterine Fibroids
☐ Hysterectomy with Removal of Ovaries
☐ Partial Hysterectomy (Uterus Only)
☐ Oophorectomy (Ovaries Only)

Please check (✓) if you have a family history of any of the following:

☐ Breast Cancer _____
☐ Colon Cancer _____
☐ Ovarian Cancer _____
☐ Osteoporosis _____
☐ Diabetes _____
☐ Hypertension _____
☐ Heart Disease _____
☐ Kidney Disease _____

MENSTRUAL HISTORY

If you no longer have periods, please check (✓) reason:

☐ Menopause ☐ Hysterectomy ☐ Ablation

If applicable, at what age did you start menopause? _____

If you have had a hysterectomy, what year? _____

☐ Partial ☐ Complete Reason: _____

Do you have PMS symptoms? ☐ Yes ☐ No

Are you still in the menstruation stage of life? ☐ Yes ☐ No

Have you ever suffered from any of the following?

☐ Menstrual/Clinical Migraines ☐ PCOS ☐ Endometriosis ☐ Fibroids ☐ Fibro Breast Disease

First day of last period: _____

Are your periods regular? ☐ Yes ☐ No Days between periods: _____

Do you have bleeding between periods? ☐ Yes ☐ No

Do you have cramping with your period? ☐ Yes ☐ No

ANDROPAUSAL RATING SCALE / MALE SYMPTOMS

Please rate symptoms 0-3: 0=none, 1=mild, 2=moderate, 3=severe

Patient Name: _____ DOB: _____

					Comments, if any:
(E)					
Sleep Disturbances (difficulty falling asleep, sleeping through the night, waking early)	0	1	2	3	_____
Depression (feeling sad, down, on the verge of tears, lack of drive, mood swings)	0	1	2	3	_____
Irritability (feeling nervous, inner tension, aggression)	0	1	2	3	_____
Anxiety (restlessness, feeling panicky)	0	1	2	3	_____
Hot Flashes / Night Sweats (episodes of sweating, flushing of face and neck)	0	1	2	3	_____
Weight Concerns/Belly Fat (please list concerns)	0	1	2	3	_____
(T)					
Hair Loss / Shedding	0	1	2	3	_____
Energy Level (general decrease in performance)	0	1	2	3	_____
Focus (impaired memory, decrease in concentration, forgetfulness)	0	1	2	3	_____
Sex Drive (change in sexual desire, sexual activity, and satisfaction)	0	1	2	3	_____
Erectile Quality (change in strength of erection or ability to keep an erection)	0	1	2	3	_____
Body/Joint Pains (pain in joints, muscular discomfort, rheumatoid complaints)	0	1	2	3	_____
Physical Activity/Stamina (extreme tiredness during/after physical activity)	0	1	2	3	_____
Migraines	0	1	2	3	_____

FOR OFFICE USE ONLY

Dose/Recommendation:

Nurse/MA Initials: _____

MALE PRIMARY CARE / UROLOGY

Please check any of the following that apply

- ☐ I have completed my family.
- ☐ I am married.
- ☐ I am sexually active.
- ☐ I want to be sexually active.
- ☐ I do not want to be sexually active.
- ☐ I have a history of using steroids for exercise performance.
- ☐ My sex life has suffered.
- ☐ I have not been able to have an orgasm or it is really difficult.

Have you had a medical / urological exam in the past year? ☐ Yes ☐ No

Have you ever had an elevated PSA or enlarged prostate? ☐ Yes ☐ No

Have you had a prostate exam or PSA test? ☐ Yes ☐ No

If so, what were the results? _____

Have you ever had Venereal Disease? ☐ Yes ☐ No

Have you ever had a urinary tract infection? ☐ Yes ☐ No

SOCIAL HISTORY

Patient Name: _____ DOB: _____

Do you smoke cigarettes, cigars, or vape? ☐ Yes ☐ No

If **yes**, amount per day? _____ How many years? _____

Do you use smokeless tobacco? ☐ Yes ☐ No

If **yes**, how often per day? _____ How many years? _____

Do you drink alcohol? ☐ Yes ☐ No

If **yes**, how often and how much do you consume? _____

Do you use marijuana or other illegal substances? ☐ Yes ☐ No

Substance: _____ How often? _____

Average Hours of Sleep Per Night: _____ Average Ounces of Water Per Day: _____

Average stress level on a scale of 1-10, with 10 being the highest: _____

Significant Stress in Your Life: _____

How often do you exercise per week? ☐ Never ☐ 1-2x ☐ 3-4x ☐ 5x+

Types of Exercise: _____

Please complete the following if you are experiencing weight concerns:

How satisfied are you with your weight?

☐ Very Unsatisfied ☐ Somewhat Unsatisfied ☐ Neutral ☐ Somewhat Satisfied ☐ Very Satisfied

What weight concerns do you have? _____

Are you currently at your heaviest weight? ☐ Yes ☐ No

If **no**, how much did you weigh at your heaviest? _____

How long has your weight concerned you? _____

Have you recently experienced hormonal weight gain, specifically in your midsection? ☐ Yes ☐ No

What is the reason you want to lose weight? _____

Have you lost weight in the past? ☐ Yes ☐ No

If **yes**, what type of programs worked for you? _____

If **not**, what type of programs did not work for you? _____

Are you a stress eater? ☐ Yes ☐ No Do you eat in the middle of the night? ☐ Yes ☐ No

What is your worst dietary habit? _____

Does your significant other struggle with weight issues? ☐ Yes ☐ No

Will friends and family support your attempt to make food & lifestyle changes? ☐ Yes ☐ No

What is your desired weight loss goal? _____

Please sign, indicating all information provided is accurate and complete.

Patient Signature: _____ Date: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Date of Birth: _____ Today's Date: _____

Please read the following statements carefully.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare options.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. This notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our notice accompanies this consent form. We encourage you to read it carefully before signing this consent.

We reserve the right to change our privacy policies as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice which will contain all changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, included any revisions of our notice, at any time by contacting either office location's Practice Manager.

Charleston: (843) 606-2530
Columbia: (803) 454-8500

RIGHT TO REVOKE: You will have the right to revoke consent at any time by giving us written notice of your revocation submitted to the Practice Manager of each individual office location listed above. Please understand that revocations of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

Please list anyone you would like to be allowed to review your protected health information if/when in the event you are unavailable.

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____
4. Name: _____ Phone: _____

VOICEMAIL/ TEXT MESSAGES: Please check (✓) one

☐ I give permission for Carolina Hormone and Health Center staff members to leave messages, with discretion, on voicemail or via text for the phone numbers listed above.

☐ Confidential information may **not** be left on voicemail.

ACKNOWLEDGMENT: I, _____, have had full opportunity to read and consider the content of this Consent Form and you Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative/parent guardian on behalf of the patient, please complete the following:

Representative's Name: _____
Relationship to Patient: _____
Signature: _____

CANCELLATION / NO-SHOW POLICY

1. **CANCELLATIONS:** We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. Due to high demand of our time and providers, we have set policies in place to ensure we can provide our patients with the best possible care.

Please allow at least 24 hours' notice for cancellation or rescheduling to avoid being charged the fee of fifty dollars ($50). Reminder confirmation texts and phone calls are sent to each patient. Our inability to contact you to confirm your appointment does not constitute an exemption from our cancellation policy. It is the patient's responsibility to cancel their scheduled appointment. You have the ability to cancel by calling the Charleston office at (843) 606-2530 or the Columbia office at (803) 454-8500. We have a 24 hour answering service.

2. **NO SHOWS:** Patients who do not show up for their appointment and do not call to cancel their appointment at least 24 hours in advance will be considered a No Show. **If you No Show your appointment, you will be charged a fee of fifty dollars ($50).**

3. **LATE APPOINTMENTS:** As a courtesy to all patients on time for their appointments, if you arrives 10 minutes or more past your scheduled appointment time, we reserve the right to reschedule your appointment and **you will be charged a fee of fifty dollars ($50).**

A card will be required and added to your patient profile. This card will only be charged if necessary to fulfill our cancellation/no-show policy.

Please sign, indicating you have read, understand, and agree to the above policies.

Patient Signature: _____ Date: _____
(or Legal Representative)

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AUTHORIZATION FOR REQUEST OF PROTECTED HEALTH INFORMATION

Please complete and send to your physician PRIOR to your upcoming appointment. It is MANDATORY for your Provider to have your current pap and mammogram report prior to your next appointment or you will be required to sign a wavier.

_____
Your Doctor's Name

_____
Address

_____
City State Zip

Phone: (_____) _____-_____

Fax: (_____) _____-_____

Patient Name: _____

Date: _____

Date of Birth: _____

Phone #: _____

I, _____, authorize, _____
Patient Name Doctor's Name

to disclose and release any individually identifiable health information related to me from **the last 2 years** only, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply):

- ☐ All Records
- ☐ Mammography
- ☐ Pap Smear
- ☐ Prostate Exam
- ☐ Treatment Notes
- ☐ Laboratory Reports
- ☐ Biopsy Results
- ☐ History and Physical

WE DO NOT ACCEPT MEDICAL RECORDS ON CD'S, DVD'S, OR FILMS.
PLEASE ONLY SEND PAPER COPIES. THANK YOU!

Send To: Carolina Hormone and Health Center
300 W Coleman Blvd. Suite 101
Mt Pleasant, SC 29464
Phone: (843) 606-2530
Fax: (843) 606-2596

Purpose: ☐ At the request of the patient / patient representative
☐ Other reason _____

Print Name: _____ Records Needed By (date): _____

Patient Signature: _____ Date: _____

AUTHORIZATION FOR REQUEST OF PROTECTED HEALTH INFORMATION

Please complete and send to your physician PRIOR to your upcoming appointment. It is MANDATORY for your Provider to have your current pap and mammogram report prior to your next appointment or you will be required to sign a wavier.

_____
Your Doctor's Name

_____
Address

_____
City State Zip

Phone: (_____) _____-_____

Fax: (_____) _____-_____

Patient Name: _____

Date: _____

Date of Birth: _____

Phone #: _____

I, _____, authorize, _____
Patient Name Doctor's Name

to disclose and release any individually identifiable health information related to me from **the last 2 years** only, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply):

- ☐ All Records
- ☐ Mammography
- ☐ Pap Smear
- ☐ Prostate Exam
- ☐ Treatment Notes
- ☐ Laboratory Reports
- ☐ Biopsy Results
- ☐ History and Physical

WE DO NOT ACCEPT MEDICAL RECORDS ON CD'S, DVD'S, OR FILMS.
PLEASE ONLY SEND PAPER COPIES. THANK YOU!

Send To: Carolina Hormone and Health Center
3231 Sunset Blvd. Suite C
West Columbia, SC 29169
Phone: (803) 454-8500
Fax: (803) 454-8505

Purpose: ☐ At the request of the patient / patient representative
☐ Other reason _____

Print Name: _____ Records Needed By (date): _____

Patient Signature: _____ Date: _____