

ITC Compounding & Natural Wellness Pharmacy

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www.itcpharmacy.com

ZRT Testing Guidelines

Thank you for choosing to use ITC Compounding Pharmacy. We are dedicated to providing a clear and concise plan to work with your physician in balancing your hormones. Enclosed please find your ZRT Laboratory Testing kit as well as a few packets of information:

Medical History Forms – please fill out and return to ITC Pharmacy.

Yeast Questionnaire - please fill out and return to ITC Pharmacy.

Dr. Wilson's Daily Information Sheet – these are the last three pages of this packet, please fill out on the day you test and return to ITC pharmacy.

In your ZRT Test Kit you will find:

1 ZRT Laboratory Form – please fill out and return with your test tubes to ZRT Laboratory.

1 ZRT Test Guide – please read before you begin to test.

1 Blood Spot Testing Instructions

2 Unistik Needles – to poke your finger with.

1 Blood Sample Card – place 1 good-sized drop of blood on each circle.

1 Diagnostic Sample Bag – place your filled test tube, blood sample card and lab form back in the plastic box and insert the box into the sample bag.

*1 UPS Air label – place on the UPS bag. ****It is important that the package be shipped on Monday – Wednesday. NOT Thursday – Sunday. If your test date falls on Thursday – Sunday, complete your test as directed, place your completed test tubes in your freezer and mail on Monday.*****

*4 Test Tubes – If you are still cycling, you need to test on day 20 of your period. Count the first day of your flow as day one. If you have irregular cycles or have a cycle longer or shorter than 28 days please call before testing to determine your test day. On the morning of your test, rinse your mouth out with water only, **DO NOT EAT, DRINK OR BRUSH YOUR TEETH BEFORE TESTING!** Begin with the tallest test tube and allow yourself a minimum of 30 minutes to fill the test tube $\frac{3}{4}$ of the way full. Please note that "spit bubbles" do not count and if your tubes are not filled appropriately you will need to test again. Begin your second tube 30 minutes before your meal, begin your third test tube 30 minutes before your meal, and your fourth test tube 30 minutes before your bedtime.. **DO NOT EAT, DRINK, OR CHEW GUM AT LEAST TWO HOURS BEFORE TESTING.***

If you are currently using any hormone creams, use them 12 hours prior to testing and apply below your waist only. Wash your hands and avoid contaminating the upper half of your body. If doing the blood spot testing you should apply your hormones directly to the inside of your forearm and rub your arms together until cream is absorbed. Avoid using your fingers to apply the hormones for 36 hours prior to testing.

We should receive your test results in approximately three weeks; at that time we will call you to set up a consulting appointment with Becky Slomiany N.P. Becky sees patients on Wednesdays and her consulting fee is \$200.00 for up to one and a half hours; each additional 15 minutes will be billed at \$30.00. If you have questions at any time during or after testing please call us at (303) 663-4224 x507.

ITC Compounding Pharmacy FAQ's (Frequently Asked Questions)

1. What hormones should I be tested for? ITC suggests that the first test include the sex hormones (estradiol, progesterone, testosterone, DHEA collected in the am) and adrenal stress index (four cortisols collected in the am, noon, pm, and bedtime). Since the stress hormones (cortisol, epinephrine) are made from the same “building blocks” as the sex hormones but have priority over these building blocks, they can use them up and not leave enough to keep your sex hormones balanced. That makes it important to test to see if stress is a component in the overall balance problem.
2. Why does ITC suggest using salivary testing and not blood testing? We believe that salivary testing for hormones is more accurate than blood for the following reasons:
 - a. Hormones are lipids (fats), which do NOT dissolve well in water, and blood is mostly water.
 - b. In blood, hormones attach themselves to red blood cells and protein molecules and they “carry” them around. Laboratory blood is “spun” to remove all the red blood cells and protein. The remaining clear serum is tested for ingredients. Therefore, the remaining sex hormones which are only 1 to 2% of the actual hormones floating in the blood are tested. Results based on 1 to 2 % are frequently wrong.
 - c. Although saliva is mostly water, the free hormones in it correlate to about 98% of what is carried in the blood by the red blood cells and protein molecules. Results based on 98% are much more accurate than results based on 1 to 2 %.
 - d. The reason saliva is so sticky and thick is partially due to the hormones in it.
3. How much does the test cost? Costs vary depending on the type of test you are taking. The ZRT Hormone Profile III kit, which is the most economical comprehensive test, includes estradiol, progesterone, testosterone, DHEA, and adrenal stress index (cortisol am, noon, pm, and bedtime) costs \$175.00.
4. Why should I have a consultation? As you have probably already found out, most physicians are not trained in the interpretation of salivary tests. Most of them have also not had training in balancing natural, bioidentical hormones. The consultation provides the patient with a comprehensive plan to work with the physician in balancing hormones. ITC also looks at other disease processes and makes suggestions to support the body for optimal health, which includes diet, exercise, and supplements.
5. My physician has requested that I do a salivary test. Do I have to schedule a consultation/interpretation with an ITC practitioner? Some physicians have received salivary test training and interpret their own tests so it would NOT be necessary to have an ITC practitioner consultation in this case. We can fax or mail your test results to your practitioner upon request.

Insurance Reimbursement

Name: _____
 Address: _____

Physician's Name: _____
 Address: _____

Date of Service: _____
 (Date of service is located on the test report)

Diagnosis Code(s)/ICD-9: 780.29
244.9
626.2

Place an "X" in the box next to each test that was performed.

X	Test	CPT Code	Quantity	Price
	Estriol (Saliva)	82677	1	
	Estrone (Saliva)	82679	1	
X	Estradiol (Saliva)	82670	1	20-
X	Progesterone (Saliva)	84144	1	20-
X	Testosterone (Saliva)	84402	1	20-
X	DHEA-S (Saliva)	82627	1	20-
X	Cortisol (Saliva)	82530	4	80-
	Vitamin D, 25-OH, Total (Blood)	82306	1	
	Luteinizing Hormone (Blood)	83002	1	
	Follicle Stimulating Hormone (Blood)	83001	1	
	Sometomedin C (Blood)	84305	1	
	Estradiol, Total (Blood)	82670	1	
	Progesterone, Total (Blood)	84144	1	
	Testosterone, Total (Blood)	84403	1	
	DHEA-S (Blood)	82627	1	
	Cortisol (Blood)	82533	1	
	Sex Hormone Binding Globulin (Blood)	84270	1	
	Prostate Specific Antigen (Blood)	84153	1	
X	Free Thyroxine (Blood)	84339	1	40-
X	Free Triiodothyronine (Blood)	84481	1	40-
X	Thyroid Stimulating Hormone (Blood)	84443	1	40-
X	Thyroid Peroxidase Antibody (Blood)	86376	1	40-
	Insulin, Fasting (Blood)	83525	1	
	High Sensitivity C-Reactive Protein (Blood)	86141	1	
	Hemoglobin A1c (Blood)	83036	1	
	Triglycerides (Blood)	84478	1	

Test(s) Performed by: **ZRT Laboratory**
 8605 SW Creekside Pl
 Beaverton, OR 97008

CLIA# 38D 0960950
 EIN/Tax ID # 93-1252924
 Place of Service: 81
 NPI# 1740356872

Complete your insurance Company's claim form. Attach a copy of the receipt for the kit purchase along with the doctor's order or prescription. Mail all of the information listed in addition to this form to your Insurance Company.

Dr. Wilson's Daily Information Sheet - For Use With The Cortisol Salivary Test[®]

Dear Patient,

You have been asked to take a cortisol salivary test. This test accurately measures your cortisol salivary levels at 4 different times during the day. Many things can affect cortisol levels. Therefore, the more accurately you complete the information sheet below, the more accurate we can be in interpreting the test and the better counseling you will receive.

Complete this form in addition to completing the form for your saliva hormone test kit.

Return the "Saliva Test Information Sheet" (this sheet) to us but send your completed lab forms to the laboratory along with your saliva test samples.

Do not send the "Saliva Test Information Sheet" (this Sheet) with your test samples.

Return only the "Saliva Test Information Sheet" to us.

All other completed forms go with the saliva sample to the lab in the bag provided.

Instructions for completing the "Saliva Test Information Sheet":

Carry the information sheet with you during the day you are taking saliva samples.

Please record the requested information in the spaces provided. If you are in doubt concerning how to complete the form, consult the accompanying completed sample form.

The first column on the left of the form lists the time of day. Use this column as an orientation to record all the information on the sheet according to the time at which it occurred.

The second column is to mark the times you took each saliva sample. Place an X in this column beside the correct time you took each sample. The best times for taking the samples are at 8:00 Am; 12:00 noon; 4:00 PM and 11:00 PM. These times are in bold. Take your samples at these times or as close to these times as possible.

The third column is to list your activities and events that happen during the day. It is best to use short phrases or single words. Toward the top of this column, please describe how you slept the night before. This is an important entry for proper interpretation of your test results.

The fourth column is for you to describe what signs and symptoms you experience within the 60 minutes before each saliva sample. This includes emotions as well as your observations. It is important that you take time to observe yourself and record your observations and experiences in this column. Be brief, but be thorough.

The fifth column is to record any food or drink you consume (anything that goes into your mouth, including gum) during this time. Record all your food and drink at the times they are taken during the day.

Date of Saliva Test _____
 Name _____
 Daytime Phone Number _____

Dr. Wilson's Daily Information Sheet- For Use With The Cortisol Salivary Test®

Time	Test Time	Activities	How I felt	Food & drink
6:00 AM				
6:15 AM				
6:30 AM				
6:45 AM				
7:00 AM				
7:15 AM				
7:30 AM				
7:45 AM				
8:00 AM				
8:15 AM				
8:30 AM				
8:45 AM				
9:00 AM				
9:15 AM				
9:30 AM				
9:45 AM				
10:00 AM				
10:15 AM				
10:30 AM				
10:45 AM				

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11:00 AM				
11:15 AM				
11:30 AM				
11:45 AM				
12:00 PM				
12:15 PM				
12:30 PM				
12:45 PM				
1:00 PM				
1:15 PM				
1:30 PM				
1:45 PM				
2:00 PM				
2:15 PM				
2:30 PM				
2:45 PM				
3:00 PM				
3:15 PM				
3:30 PM				
3:45 PM				
4:00 PM				
4:15 PM				
4:30 PM				
4:45 PM				

Dr. Wilson's Daily Information Sheet - For Use With The Cortisol Salivary Test® page 3

Test	Time	Activities	How I felt	Food & drink
	5:00 PM			
	5:15 PM			
	5:30 PM			
	5:45 PM			
	6:00 PM			
	6:15 PM			
	6:30 PM			
	6:45 PM			
	7:00 PM			
	7:15 PM			
	7:30 PM			
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	9:00 PM			
	9:15 PM			
	9:30 PM			
	9:45 PM			
	10:00 PM			
	10:15 PM			
	10:30 PM			
	10:45 PM			
	11:00 PM			

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ITC PHARMACY'S CONFIDENTIAL HORMONE EVALUATION

MEDICAL HISTORY

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail Address: _____

Gender: Male Female Height: _____ Weight: _____

Do you use tobacco? Yes No
Do you use alcohol? Yes No
Do you use caffeine? Yes No

How often and how much?

Doctor's Name: _____ Address: _____ Phone: _____

Allergies: Please check all that apply

- | | | | |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Morphine | <input type="checkbox"/> Dye allergies | <input type="checkbox"/> Seasonal (pollen) allergies |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nitrate allergy | <input type="checkbox"/> No known allergies |
| <input type="checkbox"/> Sulfa drug | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Pet allergies | <input type="checkbox"/> Other: |

Please describe the allergic reaction you experienced and when it occurred:

Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly:

- | | |
|---|---|
| <input type="checkbox"/> Pain reliever | <input type="checkbox"/> Combination product (cough+cold reliever; e.g. Triaminic DM) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sleep aids (e.g. Excedrin PC, Unisom, Sominex, Nytol) |
| <input type="checkbox"/> Acetaminophen (e.g. Tylenol) | <input type="checkbox"/> Antidiarrheals (e.g. Imodium, Pepto Bismol, Kaopectate) |
| <input type="checkbox"/> Ibuprofen (e.g. Motrin IB) | <input type="checkbox"/> Laxatives/stool softeners (e.g. Doxidan, Correctol) |
| <input type="checkbox"/> Naproxen (e.g. Aleve) | <input type="checkbox"/> Diet aids/weight loss (e.g. Dexatril) |
| <input type="checkbox"/> Ketoprofen (Orudis KT) | <input type="checkbox"/> Antihistamine (e.g. Chlor-Trimeton) |
| <input type="checkbox"/> Decongestant (e.g. Sudafed) | <input type="checkbox"/> Acid blockers (e.g. Tagamet HB, Pepcid C, Zantac 75) |
| <input type="checkbox"/> Antacids (e.g. Maalox, Mylanta) | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Cough suppressant (e.g. Robitussin DM) | |

How many pregnancies have you had? _____ How many children? _____

Any interrupted pregnancies? No Yes (Date of surgery) _____

Have you had an hysterectomy? No Yes
Ovaries removed? No Yes

Have you had a tubal ligation? No Yes

Do you have a family history of any of the following: (Please check all that apply and note family member)

Uterine cancer	_____	Family member(s)	_____
Ovarian cancer	_____	Family member(s)	_____
Fibercystic breast	_____	Family member(s)	_____
Breast cancer	_____	Family member(s)	_____
Heart disease	_____	Family member(s)	_____
Osteoporosis	_____	Family member(s)	_____

Have you had any of the following tests performed? Check those that apply and note date of last test

Mammography	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date: _____
PAP smear	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date: _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? No Yes Date: _____

If YES, please explain (such as age when occurred, symptoms...)

When was your last period? _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? No Yes

If YES, please explain symptoms:

PATIENT NAME: _____

Nutritional/Natural Supplements: Please identify and list the products you are using

- Vitamins (e.g. multiple or single vitamins such as B complex, E, C, beta carotene)

- Minerals (e.g. calcium, magnesium, chromium, colloids, various single minerals)

- Herbs (e.g. Ginseng, Gingko Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc)

- Enzymes (e.g. digestive formulas, papaya, bromelain, CoEnzyme Q10, etc)

- Nutrition/protein supplements (e.g. shark cartilage, protein powders, amino acids, fish oils, etc)

- Others (glucosamine, etc)

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

- | | |
|--|--|
| <input type="checkbox"/> Heart disease (e.g. Congestive heart failure)
<input type="checkbox"/> High cholesterol or lipids (e.g. Hyperlipidemia)
<input type="checkbox"/> High blood pressure (e.g. Hypertension)
<input type="checkbox"/> Cancer
<input type="checkbox"/> Ulcers (stomach, esophagus)
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Hormonal related issues
<input type="checkbox"/> Lung condition (e.g. asthma, emphysema, COPD) | <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 (glaucoma, etc)
<input type="checkbox"/> Other: Please list: _____
<hr/> |
|--|--|

Current Prescription Medications:

Medication Name	Strength	Date started	How often per day

List Hormones Previously Taken	Date started	Date stopped	Reason

Bone Size Small Medium Large

Body Type: Androgenic Estrogenic

Have you ever used oral contraceptives? No Yes
 Any Problems? No Yes
 If YES, describe any problem(s)

PATIENT NAME: _____

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

Doctor Self Friend/family member Other

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						
Day 4						
Day 5						

What are your goals with taking HRT?

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy

PATIENT NAME: _____

Name: _____

Date: _____

Hormone Replacement Therapy Patient Information Sheet

	Absent	Mild	Moderate	Severe
Fibrocystic breasts	_____	_____	_____	_____
Uterine fibroids	_____	_____	_____	_____
Weight gain - waist	_____	_____	_____	_____
Weight gain - hips	_____	_____	_____	_____
Heavy/irregular menses	_____	_____	_____	_____
Hot flashes	_____	_____	_____	_____
Dry skin/hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Sugar cravings	_____	_____	_____	_____
Night sweats	_____	_____	_____	_____
Vaginal dryness	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood swings	_____	_____	_____	_____
Breast tenderness	_____	_____	_____	_____
Sleep disturbance/insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid retention	_____	_____	_____	_____
Breakthrough bleeding	_____	_____	_____	_____
Fatigue - AM	_____	_____	_____	_____
Fatigue - PM	_____	_____	_____	_____
Loss of memory	_____	_____	_____	_____
Bladder symptoms/incontinence	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Harder to reach climax	_____	_____	_____	_____
Decreased sex drive	_____	_____	_____	_____
Hair loss	_____	_____	_____	_____
Cold body temp	_____	_____	_____	_____

YEAST QUESTIONNAIRE

The total score for Section A, B & C may give us the probability of yeast overgrowth being a significant factor in your case.

SECTION A: YOUR MEDICAL HISTORY

Point Score

- _____ Have you been treated for acne with tetracycline, erythromycin, or any other antibiotic for one month or longer?
50
- _____ Have you taken antibiotics for any type of infection for more than two consecutive months, or in shorter courses four or more times in a twelve-month period?
50
- _____ Have you ever taken an antibiotic – even for a single course?
6
- _____ Have you ever had prostatitis, vaginitis, or another infection or problem with your reproductive organs for more than one month?
25
- _____ Have you ever been pregnant:
Two or more times?
5
- _____ Once?
3
- _____ Have you taken birth control pills for:
More than two years?
15
- _____ Six months to two years?
8
- _____ Have you taken corticosteroids such as Prednisone, Cortef, or Medrol by mouth or inhaler for:
More than two weeks?
15
- _____ Two weeks or less?
6
- _____ When you are exposed to perfumes, insecticides, or other odors or chemicals, do you develop wheezing, burning eyes, or any other distress?
Yes, and the symptoms keep me from continuing my activities.
20
- _____ Yes, but the symptoms are mild and do not change my activities.
5
- _____ Are your symptoms worse on damp or humid days or in moldy places?
20
- _____ Have you ever had a fungal infection, such as jock itch, athlete's foot, or a nail or skin infection, that was difficult to treat and:
Lasted for more than two months?
20
- _____ Lasted less than two months?
10

Do you crave:
 _____ Sugar? 10
 _____ Breads? 10
 _____ Alcoholic beverages 10
 _____ Does tobacco smoke cause you discomfort such as wheezing, burning eyes,
 or another problem?
 10

Section A Total Score

SECTION B: MAJOR SYMPTOMS

For each symptom that is present, enter the appropriate number in the point score column:

If a symptom is occasional or mild points.	Score 3
If a symptom is frequent and/or moderately severe points.	Score 6
If a symptom is severe and/or disabling points.	Score 9

- | | Point Score |
|---|-------------|
| 1. _____ Fatigue or lethargy | |
| 2. _____ Feeling of being "drained" | |
| 3. _____ Poor memory | |
| 4. _____ Feeling "spacey" or "unreal" | |
| 5. _____ Inability to make decisions | |
| 6. _____ Numbness, burning, or tingling | |
| 7. _____ Insomnia | |
| 8. _____ Muscle aches | |
| 9. _____ Muscle weakness or paralysis | |

10. Pain and/or swelling in joints
11. Abdominal pain
12. Constipation
13. Diarrhea
14. Bloating, belching or intestinal gas
15. Troublesome vaginal burning, itching, or discharge
16. Prostatitis
17. Impotence
18. Loss of sexual desire or feeling
19. Endometriosis or infertility
20. Cramps and/or other menstrual irregularities
21. Premenstrual tension
22. Attacks of anxiety or crying
23. Cold hands or feet and/or chilliness
24. Shaking or irritable when hungry

Section B Total Score

SECTION C: OTHER SYMPTOMS

For each symptom that is present, enter the appropriate figure in the point score column:

- | | |
|---|---------|
| If a symptom is occasional or mild
point | Score 1 |
| If a symptom is frequent and/or moderately severe
points | Score 2 |
| If a symptom is severe and/or persistent
points | Score 3 |

1. Point Score
Drowsiness

2. Irritability or jitteriness

3. Lack of coordination

4. Inability to concentrate

5. Frequent mood swings

6. Headache

7. Dizziness, loss of balance

8. Pressure above ears, feeling of head swelling

9. Tendency to bruise easily

10. Chronic rashes or itching

11. Psoriasis or recurrent hives

12. Indigestion or heartburn

13. Food sensitivity or intolerance

14. Mucus in stools

15. Rectal itching

16. Dry mouth or throat

17. Rash or blisters in mouth

18. Bad Breath

19. Foot, hair, or body odor not relieved by washing

20. Nasal congestion or postnasal drip

21. Nasal itching

- 22. Sore throat

- 23. Laryngitis, loss of voice

- 24. Cough or recurrent bronchitis

- 25. Pain or tightness in chest

- 26. Wheezing or shortness of breath

- 27. Urinary frequency, urgency, or incontinence

- 28. Burning on urination

- 29. Spots in front of eyes or erratic vision

- 30. Burning or tearing of eyes

- 31. Recurrent infections or fluid in ears

- 32. Ear pain or deafness

Section C Total Score

GRAND TOTAL (Section A & B & C) _____