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.
Male Hormone Screening – 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 I 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 –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 ¾ 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 noon meal; begin your third test tube 30 minutes before your evening 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 unless told otherwise 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 you fingers to apply the hormones for 36 hours prior to testing.

We should receive your test results in two to three weeks; at that time we will call you to see if you want to set up a consulting appointment with Becky Slomiany N.P. *Becky sees patients on Wednesdays and Fridays 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.

Insurance Reimbursement

Name: ______________________ Physician's Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Date of Service: ______________________ Diagnosis Code(s)/ICD-9: __________

(Date of service is located on the test report)

____

____

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	
	Estradiol (Saliva)	82670	1	
	Progesterone (Saliva)	84144	1	
	Testosterone (Saliva)	84402	1	
	DHEA-S (Saliva)	82627	1	
	Cortisol (Saliva)	82530		
	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	
	Free Thyroxine (Blood)	84339	1	
	Free Triiodothyronine (Blood)	84481	1	
	Thyroid Stimulating Hormone (Blood)	84443	1	
	Thyroid Peroxidase Antibody (Blood)	86376	1	
	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.

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

	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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8:00 PM				
8:15 PM				
8:30 PM				
8:45 PM				
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: ________

How often and how much?

Do you use tobacco? [ ] Yes [ ] No ______________________

Do you use alcohol? [ ] Yes [ ] No ______________________

Do you use caffeine? [ ] Yes [ ] No ______________________

Doctor's Name: ____________________ Address: ____________________ Phone: ____________

____

____

____

Allergies: Please check all that apply

____ Penicillin ____ Morphine ____ Dye allergies ____ Seasonal (pollen) allergies

____ Codeine ____ Asirin ____ Nitrate allergy ____ No known allergies

____ Sulfa drug ____ Food Allergies ____ Pet allergies ____ 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:

____ Pain reliever

____ Aspirin

____ Acetaminophen (e.g. Tylenol)

____ Ibuprofen (e.g. Motrin IB)

____ Naproxen (e.g. Aleve)

____ Ketoprofen (Orudis KT)

____ Decongestant (e.g. Sudafed)

____ Antacids (e.g. Maalox, Mylanta)

____ Cough suppressant (e.g. Robitussin DM)

____ Combination product (cough+cold reliever;e.g. Triaminic DM)

____ Sleep aids (e.g. Excedrin PC, Unisom, Sominex, Nytol)

____ Antidiarrheals (e.g. Imodium, Pepto Bismol, Kaopectate)

____ Laxatives/stool softeners (e.g. Doxidan, Correctol)

____ Diet aids/weight loss (e.g. Dexatril)

____ Antihistamine (e.g. Chlor-Trimeton)

____ Acid blockers (e.g. Tagamet HB, Pepcid C, Zantac 75)

____ Other (please list)

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, colloidals, 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

____ Heart disease (e.g. Congestive heart failure)
____ High cholesterol or lipids (e.g. Hyperlipidemia)
____ High blood pressure (e.g. Hypertension)
____ Cancer
____ Ulcers (stomach, esophagus)
____ Thyroid disease
____ Hormonal related issues
____ Lung condition (e.g. asthma, emphysema, COPD)
____ Blood clotting problems
____ Diabetes
____ Arthritis or joint problems
____ Depression
____ Epilepsy
____ Headaches/migraines
____ Eye disease (glaucoma, etc)
____ Other: Please list: ____________

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: ____________

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
50
antibiotic for one month or longer?

_____ Have you taken antibiotics for any type of infection for more than two consecutive
50
months, or in shorter courses four or more times in a twelve-month period?

_____ Have you ever taken an antibiotic – even for a single course?
6

_____ Have you ever had prostatitis, vaginitis, or another infection or problem with
25
your reproductive organs for more than one month?

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

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

Point Score

1. Drowsiness

2. Irritability or jitteriness

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) __________

MALE HORMONE SCREENING

DATE ____________________

NAME ____________________

ADDRESS ____________________

PHONE ____________________

DATE OF BIRTH ____________ HEIGHT ____________ WEIGHT ____________

Rate the following as they apply to you - **Use the numbers 1-4, with 1 being Rare or Mile, and 4 being Frequent or Severe.**

		Rare	Mild	Frequent	Severe
4)	Fatigue, tiredness or loss of energy	1	2	3	4
5)	Decrease in physical stamina	1	2	3	4
6)	Feelings of depression - a sense that work, marriage or recreational activities have lost significance	1	2	3	4
7)	Decreased libido - less desire for sex	1	2	3	4
8)	Erection or potency problems	1	2	3	4
9)	Loss of early morning erection	1	2	3	4
10)	Dry skin on face or hands	1	2	3	4
11)	Increases in waist size - weight gain, especially around mid section	1	2	3	4
12)	Increased fat distribution in chest area or hips	1	2	3	4
13)	Feeling burned out, loss of motivation	1	2	3	4
14)	Increase in aches, joint and muscle pains	1	2	3	4
15)	Frequent use of alcohol - now or in the past	1	2	3	4
16)	Increased irritability, anger or bad temper.	1	2	3	4
17)	Decrease in muscle mass	1	2	3	4

18) The age you are: ______ The age you feel: ______

What non-prescription drugs are you taking (include vitamins, herbal products, or other supplements) ____________________

____

What medical conditions are you being treated for: ____________________

____

What medical conditions have you been treated for in the past 5 years? ____________