

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 Hormone Hotline Directory – an information resource for you.

1 UPS Express Bag – place your filled test tubes and lab form back in the plastic box and insert the box into the UPS 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 noon meal, begin your third test tube 30 minutes before 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 and apply below your waist only. Wash your hands and avoid contaminating the upper half of your body. Please do not use any creams on yourself that you would not apply to a baby's bottom at least 3-4 days before testing (i.e. wrinkle creams, sun block, etc.) Some of these creams have hormones in them and may cause skewed test results. If you are taking any other medications please check with the office staff before 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.

INSURANCE REIMBURSEMENT

Name: _____
 Address: _____

Physician's Name: _____
 Address: _____

Date of Service: _____

Diagnosis Code(s) / ICD-9: _____

*Date of service will be located on the test result report mailed to you by ZRT Laboratory

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

X	Test	CPT Code	Quantity	Price
	Estradiol	82670	1	
	Progesterone	84144	1	
	Testosterone	84402	1	
	DHEA-S	82627	1	
	Estriol	62677	1	
	Estrone	82679	1	
	Adrenal Function	82530	4	
	AM Cortisol	82530	1	
	PM Cortisol	82530	1	

Test(s) Performed By: ZRT Laboratory
 1815 NW 169th Place Ste. 5050
 Beaverton, Oregon 97006

CLIA # 38D 0960950
 EIN # 93-1252924

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				

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

Test		Activities	How I felt	Food & drink
Time				
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				
7:45 PM				
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				

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"/> Asirin | <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) | |

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"/> Blood clotting problems
<input type="checkbox"/> High cholesterol or lipids (e.g. Hyperlipidemia)	<input type="checkbox"/> Diabetes
<input type="checkbox"/> High blood pressure (e.g. Hypertension)	<input type="checkbox"/> Arthritis or joint problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression
<input type="checkbox"/> Ulcers (stomach, esophagus)	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Hormonal related issues	<input type="checkbox"/> Eye disease (glaucoma, etc)
<input type="checkbox"/> Lung condition (e.g. asthma, emphysema, COPD)	<input type="checkbox"/> 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 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

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 | <u> </u> |
| 2. | Irritability or jitteriness | <u> </u> |

- 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)
