



Keystone Pharmacy's Consulting Services

4021 Cascade Road SE • Grand Rapids, MI 49546 •

Phone (616) 974-9792 • Fax (616) 464-3469

Hours of Operation:

Monday – Thursday 8:30-2:30pm

(Appointments will be accommodated outside of these hours as per patient's needs)

About Our Consultation Services

Keystone Pharmacy's Consulting Services are available to men and women of any age. Consultations are done by **appointment only** either in person or on the telephone. We provide our clients with a Consultation Personal & Health History Questionnaire prior to his/her appointment. Following the consultation and/or attaining test results, we will recommended (if appropriate) a hormone therapy dosage to your physician. This recommendation is then faxed to our client's physician for approval. There is a possibility, although diminutive, a physician may not approve our recommendation (please ask for a list of recommended physicians or have physician sign Authorization to Consult form in advance). We ask that our clients verify their prescription has been approved before stopping in to pick it up or expecting it to be shipped. **Upon approval by the physician, you may pick your prescription up within 24 business hours.**

To make an appointment: Please call 616-974-9792 or email us at info@keystonerx.com to schedule an appointment. We ask our patients to leave their name, telephone number and address where they can be reached. Our consulting pharmacists will then send a letter confirming the appointment, along with a Consultation Personal & Health History Questionnaire for our client to complete and turn in prior to his/her appointment [please email the completed form to mbpre@mac.com or fax (616)-464-3469]. We ask that the staff be informed if there are time limitations involved with scheduling (ex. I have no more than 20 minutes). Arriving more than **10 minutes late** may cause your appointment to be cancelled and **rescheduled**. Less than 24 hour cancellation may be subject to a \$25.00 fee. Please bring all prescription medications, over the counter medications, vitamins, supplements and herbal treatments with you to your appointment. The actual containers or bottles are important.

Achieving hormonal balance: It is important to know regaining hormonal balance is a delicate and sometimes lengthy process. Hormone dosing is unique to each patient and proper diet, nutrition and exercise all play a role in effectively balancing hormones. Therefore, it may take a number of months before results become manifest. Recommended **adjustments** to your prescription, submitted to your physician for approval, **will not** be considered prior to the second month of therapy. Adjustments, if necessary, can only be assessed per scheduled follow up consultation.

Life Style Modifications: Adequate exercise and stress management are important to implement, as they play an important role in our health. Excessive use of alcohol/recreational drugs, prescription medications and certain disease states may affect our well-being.

Supplements: A healthy diet is key to optimal health. A diet rich in: vegetables, fruits, whole grains, essential fats, fat-free or low-fat milk and milk products, lean meats, poultry, fish, beans, eggs, and nuts is recommended. Unfortunately, the fast-paced lifestyle of many Americans very often leads to a diet lacking the essential foods that should be present in a healthy diet. Supplementation and nutraceuticals can be used to regain these vital nutrients. Most of our BHRT patients begin the following regimen (there are exceptions based on individual needs):

- OsteoSheath (Calcium/Magnesium /Vitamin D)
- Multi-Vitamin and B complex
- Indole-3-Carbinol or DIM
- EPA/DHA (essential fatty acids)
- Probiotic Therapy
- Alpha Lipoic Acid or other super anti-oxidant

The Consultation fees are as follows:

Initial Consult	\$200.00
The consultation includes:	
• An initial 1 hour consultation with	
• Scheduled 15 minute follow up consultations at no additional charge within one calendar year.	
Extension of consultation services for one year for established patients	\$100.00

Additional services* (may be needed for assessment and therapy recommendation).

Saliva Testing:	Complete panel	\$150.00
	Individual Hormones	\$ 50.00
Adrenal stress index		\$160.00

Mary PreFontaine, R.Ph, Anti-Aging & Functional Medicine Fellow
Women's Health Specialist



Mary PreFontaine is a registered pharmacist and graduate of Ferris State University School of Pharmacy. In addition to her extensive training in traditional pharmacy topics, Mary is uniquely qualified to work with prescribers to customize hormone therapies. She has received advanced training in clinical aspects of women's health including proper consideration and use of hormones for men and women. In addition to women's health issues, she has completed her fellowship in Anti-Aging & Functional Medicine (a title rare to Pharmacists) and become board certified as a Health Practitioner by The American Board of Anti-Aging.

* Please note that most insurance companies do not cover saliva hormone testing or Consultations. Various insurances, however, cover hormone replacement. We do not bill insurances for consultations or saliva testing, although we will attempt to bill your prescription to insurance.

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CONSULTATION PERSONAL & HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PERSONAL and BILLING INFORMATION			
Name (Last, First, M.I.):			
<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Social Security#	Height Weight
Address		City	Zip:
Home Phone	Work Phone	Cell Phone	Email
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Previous or referring doctor		Date of last physical exam	
Doctor's Address		City	State
Doctor's phone #		Doctor's fax #	
Occupation		Employer	
Name of Prescription Insurance		Insurance ID/Contract #	
Insurance Group #	Insurance Cardholder's name	Cardholder's Relation to self	
Phone number on the back of your card for customer service			
Name of Credit Card		Credit Card #	Expiration
Cardholder's name as it reads on the card			
Portage Pharmacy, Keystone or Sturgis Family Pharmacy is authorized to bill my credit card for consultation services and/or product wanted by myself and has my permission to keep on file and bill appropriate shipping fees if applicable: <input type="checkbox"/> YES <input type="checkbox"/> NO			
PERSONAL HEALTH HISTORY			
List any medical problems that other doctors have diagnosed			
Surgeries			
Year	Reason	Hospital	
Other hospitalizations			
Year	Reason	Hospital	
List your prescribed drugs, over-the-counter drugs, supplements, vitamins, inhaler and any hormone replacements that you take EVERY DAY or ON OCCASSION			
Name the Drug	Strength	Frequency Taken	

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Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?				
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Are you binge eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If, so how often?	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

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If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If not trying for a pregnancy list contraceptive or barrier method used:		
Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS	
Father				Children <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F			
Mother							
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>				
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>				
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>				
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>				

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MAIN REASON FOR SCHEDULING A CONSULT TODAY

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WHAT ARE THE GOALS YOU HOPE TO ACHIEVE FROM THIS CONSULT

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HOW DID YOU FIND OUT ABOUT KEYSTONES BHRT CONSULTING SERVICES?

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WOMEN ONLY					
Age at onset of menstruation:	Would you consider your cycles to be normal? If yes, explain:				
Date of last menstruation:	How many days did it last?				
Period every days					
Heavy periods, irregularity, spotting, pain, or discharge?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies		Number of live births			
Are you pregnant or breastfeeding?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had or do you have a family history of the following? <input type="checkbox"/> Uterine CA <input type="checkbox"/> Fibrocystic breasts <input type="checkbox"/> Heart disease <input type="checkbox"/> Ovarian CA <input type="checkbox"/> Breast CA <input type="checkbox"/> Endometriosis <input type="checkbox"/> Osteoporosis					
Have you ever					
Any urinary tract, bladder, or kidney infections within the last year?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last: <input type="checkbox"/> Pap _____ pos/neg <input type="checkbox"/> Rectal exam _____ pos/neg <input type="checkbox"/> Mammogram _____ pos/neg					
CURRENT SYMPTOMS					
<u>Symptom</u>	<u>ABSENT</u>	<u>MILD</u>	<u>MODERATE</u>	<u>SEVERE</u>	
Weight gain					
Heavy/Irregular menses					
Hot Flashes/Night Sweats					
Dry skin/hair and/or Hair loss					
Anxiety					
Depression					
Vaginal Dryness					
Headaches					
Irritability/Mood Swings					
Breast Tenderness					
Sleep disturbances/insomnia					
Extreme cramps					
Fluid retention/bloating					
Breakthrough bleeding					
Fatigue					
Loss of memory					
Loss of bladder control symptoms					
Decreased libido/sex drive					

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MEN ONLY

Have you noticed any of the following physical symptoms?

- Less body hair?
- Obesity
- Gynecomastia (breast enlargement)
- Decreased muscle mass
- Osteoporosis
- Repeated inability to achieve or maintain an erection sufficient for sexual intercourse

Do you experience difficulty getting urination started? Yes No

Do you usually get up to urinate during the night? Yes No

If yes, # of times

Do you feel pain or burning with urination? Yes No

Any blood in your urine? Yes No

Do you feel burning discharge from penis? Yes No

Has the force of your urination decreased? Yes No

Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No

Do you have any problems emptying your bladder completely? Yes No

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

Date of last prostate and rectal exam?

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Informed Consent Form

Date:

Name:

DOB:

Address:

City:

State:

Zip:

Phone/Home:

Cell:

I hereby release Keystone Pharmacy and its employees and affiliates from any and all responsibility or liability arising from or in any way connected with screenings, consultations or our weight management programs. I understand that:

1. The data and/or results derived from such screenings, testing, consultations and programs are to be considered preliminary only. The results are in no way conclusive and do not constitute a diagnosis of a medical condition.
2. The responsibility for initiating any follow-up care to confirm the results through screenings or testing and obtain professional medical assistance is mine alone, and not that of Keystone pharmacy and its affiliates.
3. My personal medical file will be shared with the prescribing physician. No other person will have access to my file without my express verbal or written permission. Aggregate data may be used for statistical and research purposes only.

Signature