After filling in this page, please mail it to: hairgrowth@regenboogapotheek.com

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1. Initials and name patient: . . . . . .

Date of birth: . . - . . - . . . . Sex: ☐ M / ☐ F ID-number: . . . . . .

Street and house-number of patient: . . . . . .

. . . . . .

Postal Code and City: . . . . . Country: . . . . . .

E-mail address of patient (**mandatory**): . . . . . .

Phone: . . . . . .

Patient gives permission to receive medication from Regenboog Apotheek (Rainbow Pharmacy) ☐ YES

Make sure to inform your local pharmacy about the use of this medicine!
If email address and confirmation box aren't filled in, we can't send the medication!

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2. Name practitioner: . . . . . .

Registration number of practitioner: . . . . . .

Street and house number of general practice: . . . . . .

. . . . . .

Postal Code and City: . . . . . .

E-mail address (**mandatory**): . . . . . .

Phone: . . . . . .

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3. CROSS THE BOX IN THE TABLE WHICH MEDICATION AND DOSE YOU WOULD LIKE TO PRESCRIBE:

	MEDICINE	DOSE	QUANTITY
☐	Minoxidil	1mg	100 tablets
☐	Minoxidil	1mg	365 tablets
☐	Minoxidil	1,25mg	100 tablets
☐	Minoxidil	1,25mg	365 tablets
☐	Minoxidil	2,5 mg	100 tablets
☐	Minoxidil	2,5 mg	365 tablets

Daily dosage (if other than one tablet once daily) ……

Date: Signature practitioner:

(+ stamp preferably):