

After filling in this page, please mail it to: [hairgrowth@regenboogapothek.com](mailto:hairgrowth@regenboogapothek.com)

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!**

2. Name practitioner: .....  
Registration number of practitioner: .....  
Street and house number of general practice: .....  
.....  
Postal Code and City: .....  
E-mail address (**mandatory**): .....  
Phone: .....

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

	MEDICINE	DOSE	QUANTITY
<input type="checkbox"/>	Dutasteride	0,1 mg	100 tablets
<input type="checkbox"/>	Dutasteride	0,1 mg	365 tablets
<input type="checkbox"/>	Dutasteride	0,15 mg	100 tablets
<input type="checkbox"/>	Dutasteride	0,15 mg	365 tablets
<input type="checkbox"/>	Dutasteride	0,25 mg	100 tablets
<input type="checkbox"/>	Dutasteride	0,25 mg	365 tablets
<input type="checkbox"/>	Dutasteride	0,5 mg	100 tablets
<input type="checkbox"/>	Dutasteride	0,5 mg	365 tablets

**Daily dosage** (if other than one tablet once daily) .....

Date:

Signature practitioner:  
(+ stamp preferably):