**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 |
|---|---|---|---|
| ☐ | Finasteride | 0,5 mg | 100 tablets |
| ☐ | Finasteride | 0,5 mg | 365 tablets |
| ☐ | Finasteride | 1 mg | 100 tablets |
| ☐ | Finasteride | 1 mg | 365 tablets |
| ☐ | Finasteride | 1,25 mg | 100 tablets |
| ☐ | Finasteride | 1,25 mg | 365 tablets |

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

Date: Signature practitioner:

(+ stamp preferably):