ellura®

36 mg PAC (proanthocyanidins)DMAC/A2

Patient Referral Form

Complete and fax this form to **404.736.2575**
to start your patient on **ellura** or submit at **elluraform.com**.
A Customer Care Team member will contact your patient to answer their questions and assist with ordering. ***Patients can also receive an additional $15 discount off a 90-count bottle!***

HEALTHCARE PROVIDER (required)

Physician/Clinic Stamp accepted.

____
NAME

____
OFFICE/PRACTICE NAME (IF APPLICABLE)

PHONE ____________________ EMAIL ____________________

PATIENT INFORMATION

NAME ____

PHONE NUMBER(S) __________________________________

Check recommended supply for your patient

30 DAY SUPPLY	☐
60 DAY SUPPLY	☐
90 DAY SUPPLY	☐
ONGOING USE	☐

Fax this form to **404.736.2575**
or email this information to **orders@trophikos.com**

Prefer paperless? Visit **elluraform.com**