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Hormone care policies

Document control

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Owner and approving clinician: Dr Mitesh Parmar, Clinical Director.

Status: Approved and final. Effective date: 20 October 2026. Next review: 20 October 2027, or sooner after relevant guidance, safety alerts, incidents or service changes.

This pack contains Policy A: menopause HRT; Policy B: primary hypothyroidism; and SOP C: exceptional remote continuation. These policies apply to adults and must be read with the clinic's prescribing, UK service, safeguarding and medicines safety policies.

1. Service scope

The hormone service covers menopause/perimenopause and primary hypothyroidism. Treatment is initiated face to face. Telephone and video consultations may provide advice, discuss results and arrange assessment. Remote prescribing is an exception for an established patient who is clinically stable on unchanged treatment and meets SOP C.

The clinic does not provide testosterone replacement therapy. These pathways do not authorise testosterone, growth hormone, DHEA, hCG, peptides, custom-compounded hormones, or treatment intended to produce supraphysiological hormone levels. Thyroid hormone is not prescribed for weight loss or fatigue in a person with normal thyroid function. Other endocrine conditions require an appropriate separate assessment or specialist pathway.

There is no hormone programme, membership, subscription, automatic renewal or automatic prescription. No supplements, vitamins, minerals, herbal products or nutraceuticals are recommended, sold or supplied as part of the hormone service. Treatment of a separately diagnosed deficiency is recorded as a separate clinical indication.

2. Responsibility and professional standards

A GMC-registered doctor with a licence to practise must personally assess the patient, work within their competence and accept responsibility for each prescription. The Clinical Director maintains evidence of relevant training and oversees implementation, audit and service scope. Specialist advice is sought where diagnosis, risk or treatment exceeds the clinician's competence.

Prescribing requires sufficient medical records, an individual benefit-risk discussion, informed consent, a monitoring plan and a lawful prescription. Use a suitable UK-authorised medicine where available; check its current product information. Any off-label use requires a documented clinical reason, appropriate evidence, discussion with the patient and compliance with GMC guidance. This does not authorise a new treatment service.

3. Face-to-face baseline assessment

Record symptoms, relevant examination, medical and family history, allergies, current and previous treatment, non-prescription products, pregnancy possibility, and the patient's goals. Check blood pressure, pulse, weight/BMI and cardiovascular risk; assess VTE risk where relevant to HRT. The clinic's initial assessment includes an ECG and baseline blood assessment, normally undertaken in house. Record the actual tests, clinical reasons, results and actions; a label such as 'full bloods' is insufficient.

Select the laboratory panel for the condition and differential diagnosis. It may include FBC, renal/liver function, glucose or HbA1c, lipids, thyroid tests and deficiency investigations where relevant. This broader clinic safety assessment does not make a full reproductive hormone panel necessary for every menopausal patient. Routine ECG and broad baseline assessment are clinic standards, not a claim that NICE requires them for every HRT prescription.

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Policy A · Menopause and perimenopause

A1. Indications and assessment

Assess vasomotor symptoms, sleep or mood disturbance associated with menopause, and genitourinary symptoms such as vaginal dryness or discomfort. Consider alternative causes and the effect on daily life. A symptom alone does not establish a hormone deficiency. HRT is an individual treatment choice, not an automatic response to a test result.

Record menstrual and bleeding history, age, contraception and pregnancy possibility; whether the uterus is present; hysterectomy/oophorectomy history; previous HRT and any intrauterine device's type and insertion date. Review cardiovascular disease, VTE, migraine, liver disease, breast/endometrial or other hormone-sensitive cancer, unexplained bleeding, relevant family history, smoking, BMI, interactions and current screening. Refer for specialist advice where risk or diagnostic uncertainty requires it.

A2. Diagnostic testing: number and timing

Age 45 or over, otherwise healthy, with typical menopause-associated symptoms: diagnose clinically. The routine number of FSH or oestradiol measurements to establish menopause is zero. Safety blood tests or tests for another diagnosis do not change this rule.

Age 40 to 45 with relevant symptoms and menstrual change: consider an initial FSH measurement when it will help the diagnosis. There is no universal requirement for two samples at a fixed interval in this group. Repeat testing is decided and documented if the clinical picture remains uncertain.

Suspected premature ovarian insufficiency below age 40: assess symptoms and menstrual history and obtain two elevated FSH results, on samples taken 4 to 6 weeks apart, in accordance with NICE NG23. Arrange specialist input; do not make this diagnosis from one result. This is an assessment/referral pathway rather than authority to initiate treatment remotely.

Do not use FSH to diagnose menopause during combined oestrogen-progestogen contraception or high-dose progestogen treatment. Do not routinely order oestradiol, AMH, ovarian imaging or a broad reproductive hormone panel to diagnose typical menopause at age 45 or over. Consider pregnancy testing and tests for thyroid disease, anaemia or other causes when clinically indicated.

A3. Treatment selection and consent

Initiation and planned changes of dose or route take place after face-to-face assessment. Discuss the expected benefit, uncertainties, alternatives, individual risks, bleeding expectations and review arrangements. Use the lowest effective HRT dose and choose the preparation and route individually, checking current product information and NICE guidance.

For systemic oestrogen in a patient with a uterus, provide adequate endometrial protection with an appropriate progestogen regimen. Do not confuse contraceptive duration of an intrauterine device with its duration of protection for HRT. After total hysterectomy, oestrogen-only treatment is usually appropriate, subject to individual clinical factors. Low-dose local vaginal oestrogen is a distinct treatment and does not normally require added progestogen.

Consider transdermal rather than oral HRT when VTE risk is increased; seek specialist advice where necessary. HRT is not contraception. Discuss contraception separately where relevant without expanding this policy into a remote contraception service. Patients with suspected contraindications or unexplained bleeding must be assessed before routine prescribing. Licensed body-identical preparations are not the same as custom-compounded 'bioidentical' mixtures.

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Policy A · Review, continuation and escalation

A4. Clinical review and tests during treatment

Arrange a face-to-face review approximately 3 months after starting HRT or changing treatment, then at least annually under this clinic policy. Review sooner for inadequate benefit, side effects, changed risk or a new symptom. Record symptom response, adherence and application technique, blood pressure and weight where relevant, bleeding pattern, progestogen adequacy, adverse effects, new medicines and the patient's preference.

Do not titrate routinely to an 'optimal' oestradiol, progesterone or FSH value. Persistent symptoms require assessment of diagnosis, use of the medicine, absorption, interactions and other causes. An oestradiol test may occasionally help investigate suspected poor absorption; document the question being asked and interpret the result with the preparation, dose, timing and clinical picture. A single result is not an automatic instruction to increase treatment.

Repeat safety or diagnostic blood tests only for a documented clinical or monitoring reason. A routine reproductive hormone panel is not a prerequisite to every HRT repeat prescription. An unchanged repeat may be considered remotely only under SOP C.

A5. Bleeding and other warning symptoms

Unexplained bleeding before HRT, new postmenopausal bleeding, or troublesome unscheduled bleeding requires clinical assessment. Record the pattern, HRT regimen, adherence, cancer risk and examination/investigation plan. Apply the current NICE suspected-cancer pathway and BMS unscheduled-bleeding guideline, rather than assuming all bleeding is an HRT side effect.

First bleeding more than 6 months after starting HRT, or more than 3 months after a change, generally requires urgent transvaginal ultrasound within 6 weeks under BMS guidance. Heavy/prolonged bleeding or additional cancer risks can require earlier investigation irrespective of timing. Significant acute bleeding, collapse or haemodynamic concern requires immediate urgent care. Do not defer assessment until the annual review.

Suspected pulmonary embolism, stroke or acute cardiac symptoms require emergency assessment. Suspected DVT requires urgent assessment. New breast symptoms need prompt clinical assessment and the appropriate referral pathway. Suspected cancer, serious adverse reactions or a new contraindication require an immediate prescribing review; do not continue routine repeats while the concern is unresolved.

A6. What happens when symptoms are controlled

Control of symptoms does not end a membership because the clinic has none. It also does not automatically mean HRT should stop. At each review, discuss whether the continuing benefit outweighs the individual risks and whether the patient wishes to continue, change or stop.

There is no automatic discharge or fixed treatment duration based on a hormone concentration. If stopping is appropriate, discuss gradual reduction or stopping directly, possible symptom recurrence and follow-up. Premature ovarian insufficiency requires its own specialist-informed plan and must not be managed as an ordinary short course for symptoms. Offer continuity through the clinic or an agreed transfer of care; do not assume another clinician has accepted prescribing responsibility.

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Policy B · Primary hypothyroidism

B1. Diagnosis and initial tests

Assess symptoms with the clinical history and examination; fatigue, weight change or low mood alone is not a diagnosis. Record cardiovascular disease, pulse/rhythm, pregnancy plans or pregnancy, previous thyroid surgery or radioiodine, medicines and previous results. Follow the clinic's face-to-face baseline assessment, including ECG.

Use an initial blood sample to assess TSH and FT4: FT4 may be measured reflexively when TSH is elevated, or both requested together where appropriate. Overt primary hypothyroidism can be established from one appropriate paired result and its clinical context; it does not require a routine three-month delay before indicated treatment.

For subclinical hypothyroidism (raised TSH with normal FT4), confirm persistence on two samples approximately 3 months apart before the usual treatment decision. Consider levothyroxine when TSH is at least 10 mIU/L on both samples. In symptomatic adults under 65 with persistent TSH above the reference range but below 10, a time-limited trial may be appropriate under NICE guidance. Record the individual rationale and planned review.

If other diagnostic uncertainty or changed symptoms require repeat thyroid testing, generally allow at least 6 weeks, unless a different urgent or specialist context applies. Avoid interpreting transient illness-related abnormalities as established disease. Ask about biotin, which may distort tests; follow laboratory advice on sampling. Consider TPO antibodies once where appropriate; do not repeat antibodies to monitor replacement treatment.

B2. Prescribing and monitoring

Levothyroxine is first-line treatment for primary hypothyroidism. Choose the dose with reference to age, weight, cardiovascular status, severity and current guidance/product information. Initiation and routine dose changes require face-to-face assessment under clinic policy. Liothyronine, combination T3/T4 therapy and desiccated thyroid extract are outside this routine pathway and are not initiated or repeated under SOP C.

Check TSH from 6 weeks after starting or changing levothyroxine, then approximately every 3 months until stable. Stability means two similar TSH measurements within the laboratory reference range, 3 months apart. Once stable, check at least annually; check earlier for symptoms, pregnancy, relevant interacting medicines, a formulation change or other clinical concern. Consider FT4 as well when symptoms persist.

Aim for appropriate clinical recovery and TSH within the reference range, not a suppressed TSH or an 'optimal' commercial target. Review adherence, timing with food and interacting medicines, absorption and other diagnoses before unnecessary dose escalation. Explain administration and separation from interacting products, such as iron or calcium, using the prescribed product's instructions. Persistent symptoms after switching product require review in line with MHRA advice.

B3. Stable results, special cases and safety

Normal thyroid results on levothyroxine usually show that replacement is working. Established primary hypothyroidism commonly needs long-term or lifelong treatment; do not stop solely because TSH has normalised. Review an unsuccessful trial for mild subclinical disease separately and consider stopping with a monitoring plan where NICE recommends this.

Pregnancy or planned pregnancy, suspected pituitary/central disease, thyroid cancer, a new neck mass, severe uncontrolled disease or persistent unexplained abnormalities require prompt specialist assessment or advice. Pregnancy must trigger prompt, time-sensitive dose and monitoring review; do not leave the patient without necessary thyroid replacement while arranging it. Palpitations or an irregular pulse require assessment; chest pain, syncope or severe acute illness may require emergency care.

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SOP C · Exceptional remote continuation

C1. Eligibility

An existing patient may be considered for an unchanged repeat of menopause HRT or levothyroxine only after the prescriber checks and records every item below. Remote advice alone is not permission for a prescription.

1. The diagnosis and treatment followed a face-to-face assessment, with sufficient records available to the clinic. A new patient transferring care needs a clinic face-to-face assessment before entering this repeat pathway.

2. The patient is clinically stable on an established, unchanged medicine, dose and route. Symptoms are satisfactorily controlled; there are no new adverse effects, contraindications, unexplained bleeding, pregnancy-related issues or other warning symptoms requiring assessment.

3. Monitoring is current and satisfactory. For HRT, the initial review and annual face-to-face review must be current, with no unresolved investigation. For levothyroxine, stability must have been established and the scheduled TSH check must be current, ordinarily within the preceding 12 months. A new clinical concern overrides an otherwise recent test.

4. The prescriber can establish identity, speak directly with the patient, confirm their current physical location in the UK and obtain a reliable history. Choose video rather than telephone where visual assessment or identity assurance is needed; if the medium is insufficient, arrange face-to-face care.

5. Current medicines, allergies, recent changes, relevant records and responsibilities for monitoring have been checked. Any information-sharing concern has been resolved sufficiently for safe prescribing.

6. The prescription quantity is clinically justified and does not extend beyond the next required review or monitoring point. A review date and result owner are recorded. There is no automatic repeat authorisation.

C2. During the consultation and after the decision

Record consent to the consultation, identity verification method, location, relevant history and results, medicine/dose/route, stability assessment, reasons remote continuation is safe, quantity, next review and safety-net advice. Do not claim technological identity, geographic or laboratory verification that has not actually been implemented.

Use the clinic's authorised prescribing system and pharmacy arrangements. Verify the UK delivery address and follow the UK service and medicine delivery safeguards. If the patient is outside the UK, issue no prescription and arrange no medicine; direct them to local care as appropriate. Refunds remain governed by the clinic's existing terms, service provided and applicable rights; this SOP creates no automatic refund rule.

With the patient's consent, communicate the relevant treatment and monitoring plan to their usual GP and other involved clinicians. Where consent is withheld or they have no GP, assess whether safe care is possible and who will undertake monitoring; do not assume that sending a letter transfers responsibility.

C3. When an unchanged repeat is unsuitable

Do not use this pathway for initiation, dose escalation, switching route, unstable disease, missing material records, overdue necessary monitoring or a new warning symptom. Arrange face-to-face assessment, testing or specialist care at the urgency required.

If a necessary medicine is about to run out, obtain a prompt clinician decision and coordinate safe continuity with the usual prescriber or appropriate service. Administrative staff must not abruptly discontinue treatment or improvise an exception. Any urgent safety decision outside this routine SOP must be clinically justified, documented and reviewed by the Clinical Director; it does not create a standing remote initiation or dose-change service.

Shared governance and implementation

4. Results, recalls and clinical ownership

The requesting clinician owns each investigation until responsibility has been explicitly accepted by another clinician. Record the test ordered, expected result date, result, interpretation, patient communication and action. The clinic must maintain a traceable outstanding-results and review list with cover during absence.

Act on laboratory critical alerts immediately. Chase missing results and missed necessary reviews in accordance with clinical urgency. Document attempts to contact the patient and escalate unresolved high-risk gaps to the Clinical Director. Patients must know how and when results will be communicated and whom to contact if they have heard nothing.

Before a repeat, check that relevant results and actions are complete. Record external results with patient identifiers, dates, units and laboratory reference ranges; resolve uncertainty rather than relying on an unverified number quoted during a call.

5. Supplements and medicine safety

The current hormone-service supplement list is: NONE. There are no mandatory supplement bundles, proprietary hormone packages or supplement purchases linked to access to care. A separately diagnosed deficiency may be treated on its own merits and must not be presented as a hormone-optimisation product.

Ask about patient-initiated supplements, vitamins, herbal products and medicines obtained elsewhere. Record them and check interactions and laboratory interference, particularly biotin with thyroid assays. Explain relevant uncertainty about unregulated products without implying the clinic supplies or endorses them.

Record suspected adverse reactions and medication incidents; arrange clinical care, inform relevant clinicians/pharmacy and report through the MHRA Yellow Card scheme where appropriate. Review contributing causes and amend the pathway when necessary.

6. No programme or membership

Care is based on individual clinical need, not a subscription or a commitment to reach a laboratory target. There is no automatic renewal or medicine supply. Stable patients receive ongoing monitoring, with continuation, adjustment, cessation or transfer agreed on clinical grounds and patient preference. Do not promise symptom elimination or a numerical 'optimal hormone' endpoint.

7. Implementation and audit

The Clinical Director must brief staff, confirm result/recall arrangements, implement the remote checklist and reconcile website statements. Staff must have access to the controlled copy. Do not describe a technical control as implemented without verification.

Audit annually and after a significant incident: a sample of HRT and levothyroxine initiations, reviews and remote repeats; evidence of assessment and indicated tests; review timeliness; result follow-up; remote eligibility; prescribing decisions and communication. Examine every departure identified, assign corrective action and document completion. Review earlier after a relevant NICE, BMS, MHRA or GMC change.

Retain version history. Changes to the hormone service, including a new condition, medicine category, supplement or subscription model, require clinical approval and matching changes to the website and certification answers before launch.

Approval record

Approved by Dr Mitesh Parmar, Clinical Director, on 20 October 2026.

Approval method: express written authorisation from the Clinical Director, recorded on 20 October 2026.

Effective date: 20 October 2026. Next scheduled review: 20 October 2027.

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Clinical references and document map

Sources checked 20 October 2026

Use the current source and product information at the point of care. This pack defines clinic procedures and does not replace individual clinical judgement, specialist advice or urgent care. Guidance does not make face-to-face initiation or an annual in-person review a universal legal requirement; these are Clinique Alpa's service controls.

NICE NG23, Menopause: identification and management, updated 15 April 2026: sections 1.3, 1.7, 1.8 and 1.9.

NICE NG145, Thyroid disease: assessment and management: sections 1.2 to 1.5.

NHS Specialist Pharmacy Service, Levothyroxine monitoring: baseline assessment, follow-up from 6 weeks and stable monitoring.

British Menopause Society, Measurement of serum estradiol in the menopause transition, July 2025.

British Menopause Society joint guideline, Management of unscheduled bleeding on HRT; current web guidance and linked guideline.

MHRA, Levothyroxine: new prescribing advice for patients who experience symptoms on switching between different products, 19 May 2021.

GMC, Good practice in proposing, prescribing, providing and managing medicines and devices; remote consultation principles and unlicensed/off-label prescribing guidance.

How this pack answers LegitScript Question 28

Question 28.1: Scope and face-to-face assessment on page 1; menopause and thyroid policies on pages 2 to 4; remote continuation safeguards on page 5.

Question 28.2: Menopause testing on page 2; thyroid testing and monitoring on page 4. No universal 'two hormone tests' rule is applied across conditions.

Question 28.3: HRT continuation on page 3; thyroid continuation on page 4; no memberships or automatic renewals on page 6.

Question 28.4: No hormone-service supplements, with patient-initiated product checks and separate deficiency treatment, on page 6.

Clickable source links

NICE NG23: menopause

NICE NG145: thyroid disease

NHS SPS: levothyroxine monitoring

BMS: serum estradiol measurements

BMS: unscheduled bleeding on HRT

MHRA: levothyroxine product switching

GMC: prescribing standards

GMC: remote consultation principles

GMC: unlicensed medicines