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DATE: _____

PATIENT'S NAME: _____

RE: PRE-TREATMENT TEST (FEMALE)

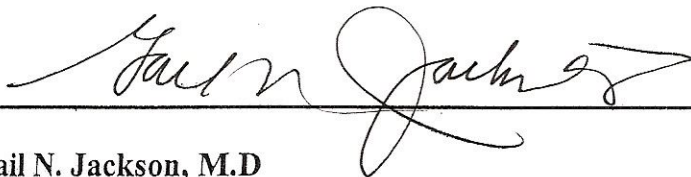
PLEASE HAVE THESE LAB TESTS PERFORMED AND FAX OR MAIL THE RESULTS TO THE ABOVE ADDRESS.

LAB TEST ORDERED:

- FSH
- TESTOSTERONE
- ESTRADIOL
- T.S.H

DX: VO7.4

Thank you,



Gail N. Jackson, M.D

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