Luteinizing Hormone (LH) Levels Test Requisition Form

Patient Information

- **Patient's Full Name**:
- **Date of Birth**:
- **Gender**:
  - ☐ Male
  - ☐ Female
- **Contact Information**:
- **Medical Record Number**:

Ordering Physician Information

- **Physician's Full Name**:
- **Clinic/Hospital Name**:
- **Contact Information**:

Test Selection

☐ LH Levels Test Only

☐ LH Levels Test with Related Tests (Specify): ____________________________

Clinical Indications

☐ Fertility Assessment

☐ Menstrual Irregularities

☐ Hormonal Imbalances

☐ PCOS Diagnosis

☐ Hypogonadism Evaluation

☐ Puberty Assessment

☐ Other (Specify): ____________________________

Specimen Information

- **Date of Blood Collection**: 10/25/2023
- **Time of Blood Collection**: 09:30 AM
- **Collector's Name**: Nurse Anna Johnson
- **Collector's Designation**: Registered Nurse

Patient Consent

I, the undersigned patient, consent to undergo the LH Levels Test for the mentioned clinical indications.

Patient's Signature: .... **Date**:

Physician's Signature: .... **Date**: