

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:**
- **Time of Blood Collection:**
- **Collector's Name:**
- **Collector's Designation:**

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:**