**Date:** [Insert Date]

**Patient Name:** [Patient Full Name]
**Date of Birth:** [DOB]
**Patient ID:** [ID Number]

**To:** [Referring Physician Name / General Practitioner]

**Subject: Pre-Treatment Gynecology Fertility Assessment Consultation**

Dear Dr. [Physician Last Name],

I had the pleasure of seeing [Patient Name] today for a comprehensive pre-treatment fertility assessment. The purpose of this consultation was to evaluate her reproductive health prior to initiating [Insert Specific Treatment, e.g., IVF, IUI, or Egg Freezing].

**Clinical History:**
[Insert brief summary of menstrual cycle regularity, duration of trying to conceive, and relevant surgical or medical history.]

**Examination Findings:**
[Insert physical examination details or pelvic ultrasound findings regarding uterine morphology and adnexa.]

**Diagnostic Results:**

- **Ovarian Reserve:** AMH: [Value], Day 3 FSH: [Value], Antral Follicle Count: [Value]
- **Tubal Patency:** [Results of HSG or HyCoSy]
- **Uterine Cavity:** [Results of Saline Infusion Sonogram or Hysteroscopy]
- **Serology:** [Results of Infectious Disease Screening]

**Assessment and Recommendations:**
Based on the findings, the patient is a suitable candidate for [Proposed Treatment Plan]. Our next steps will include [Insert Next Steps, e.g., starting stimulation protocols, nutritional optimization, or further specialty referral].

Thank you for involving me in the care of this patient. I will keep you updated on her progress.

Sincerely,

[Doctor Signature]
**[Doctor Name, Credentials]**
[Department/Clinic Name]