

Date: [Date]

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID: [ID Number]

Subject: Initiation of Testosterone Replacement Therapy (TRT)

Dear [Recipient Name/Primary Care Physician],

This letter is to confirm that [Patient Name] has been clinically diagnosed with Hypogonadism (ICD-10 Code: [Code]) following a comprehensive medical evaluation and laboratory testing.

Clinical Findings:

- Initial Total Testosterone Level: [Value] ng/dL (Tested on [Date])
- Repeat Total Testosterone Level: [Value] ng/dL (Tested on [Date])
- Symptoms: [List symptoms, e.g., fatigue, low libido, muscle loss]

Treatment Plan:

Based on the clinical presentation and laboratory results, I have initiated Testosterone Replacement Therapy (TRT) effective [Start Date]. The prescribed regimen is as follows:

- **Medication:** [Medication Name, e.g., Testosterone Cypionate]
- **Dosage:** [Dosage, e.g., 100mg]
- **Frequency:** [Frequency, e.g., once weekly]
- **Route:** [Route, e.g., Intramuscular Injection]

Monitoring and Follow-up:

The patient will undergo regular monitoring of Total/Free Testosterone, PSA levels, Hematocrit (CBC), and lipid profiles every [Number] months to ensure therapeutic efficacy and safety.

Please update the patient's medical records accordingly. If you have any questions regarding this treatment plan, please contact my office at [Phone Number].

Sincerely,

[Doctor Signature]

[Doctor Printed Name]

[Medical Practice/Clinic Name]

[License/NPI Number]