

[Date]

[Patient Full Name]

[Patient Date of Birth]

[Patient Address]

[Patient Phone Number]

To: [Laboratory Name / Provider Name]

From: [Ordering Physician/Provider Name]

Facility: [Clinic/Facility Name]

**RE: Requisition for Modified Hormone Therapy Lab Work**

To Whom It May Concern,

This letter serves as a formal requisition for laboratory services for the above-named patient. The patient is currently undergoing a modified hormone therapy regimen. To ensure clinical safety and monitor therapeutic efficacy, please perform the following diagnostic tests:

- Total Testosterone
- Free Testosterone (Calculated or Direct)
- Estradiol (Sensitive Assay)
- Sex Hormone Binding Globulin (SHBG)
- Complete Blood Count (CBC) with Differential
- Comprehensive Metabolic Panel (CMP)
- Lipid Panel
- Prostate-Specific Antigen (PSA) - [If applicable]
- Luteinizing Hormone (LH) & Follicle Stimulating Hormone (FSH)

**Clinical Indications:** Monitoring of endocrine response and metabolic health under modified hormone replacement therapy (ICD-10: [Insert Code, e.g., E34.9]).

Please forward all results via [Fax/Secure Portal/Email] to my office at [Fax Number/Contact Info] as soon as they become available.

If there are any questions regarding this request or the specific assays required, please contact our office at [Phone Number].

Sincerely,

[Signature]

[Provider Name, Title]

[NPI Number]

[Clinic Stamp/Address]