Anti-Müllerian Hormone (AMH) Test Request Form

Name: Jane Doe Date of Birth: 04/15/1985

Gender: Female Email: jane.doe@email.com Phone Number: (555) 123-4567

Address: 123 Main Street, Cityville, State

Emergency Contact: John Doe Relationship: Spouse

Medical History

- **Primary Care Physician:** Dr. Sarah Smith
- **Referring Physician:** Dr. Lisa Johnson
- **Medical Conditions:** None
- **Medications:** None
- **Allergies:** None

Consent

I, the undersigned, consent to the Anti-Müllerian Hormone (AMH) test. This test assesses my ovarian reserve and may aid fertility evaluation and treatment planning. I have been provided with information regarding the test's purpose, potential risks, and benefits, and I have had the opportunity to ask questions.

Sample Collection

- **Sample Collection Date:** 09/20/2023
- **Sample Collection Time:** 10:00 AM
- **Preferred Lab (if any):** ABC Diagnostic Lab

Physician's Notes

- **Reason for AMH Test:**

To assess ovarian reserve in the context of fertility evaluation.

- **Clinical Indications:**

The patient and her spouse are planning to start a family and have been trying to conceive for the past year without success. This test will provide valuable information regarding her ovarian reserve.

- **Additional Comments:**

The patient has expressed concerns about her fertility due to her age. This test will help us determine the most appropriate fertility treatment options.

Patient Signature: Jane Doe **Date:** 09/20/2023

Physician Information

- **Physician's Name:** Dr. Emily Martinez
- **Medical License No.:** 12345
- **Clinic/Hospital:** XYZ Fertility Clinic
- **Contact Number:** (555) 987-6543