GAIL N. JACKSON, M.D
2211 CORINTH AVE SUITE 210
LOS ANGELES, CA 90064
TEL: (310)451-2300 FAX: (310)451-2325

DATE: _____

PATIENT'S NAME: _____

RE: PRE-TREATMENT TEST (MALE)

PLEASE HAVE THESE LAB TESTS PERFORMED AND FAX OR MAIL THE RESULTS TO THE ABOVE ADDRESS.

LAB TEST ORDERED:

- ○ **Testosterone Free**
- ○ **Testosterone Total**
- ○ **P.S.A**
- ○ **Estradiol**
- ○ **T.S.H**
- ○ **Hemoglobin, Hematocrit**
- ○ **DHEA**

Thank you,

DX: E29.1

Gail N. Jackson, M.D