THE NATIONAL WOMEN'S HORMONE LABORATORY

DRAW AND SEND SPECIMEN TO:

6901 Mercy Rd. Omaha Ne 68106
Phone: 402-390-0532 Fax: 402-505-8931
CLIA # 28D043756

Thomas W. Hilgers M.D. Medical Director
Thomas W. Hilgers M.D. Laboratory Director

PATIENT INFORMATION

Name (Last, First)_____ Date of Birth____/____/_____

Address_____ Phone_____-_____-_____ Gender MALE / FEMALE

****NEW PATIENTS MUST SEND DEMOGRAPHIC INFORMATION

BILLING INFORMATION

Bill To: Patient Self-Pay / Insurance* / Client *SEND COPY OF INSURANCE CARD (Front and back)

Insurance_____ Ordering Provider_____

Subscriber ID_____ Group #_____ Provider Phone #_____-_____-_____ Fax # _____-____-_____

Name of Policy Holder _____ Signature of Provider (Required)_____

ORDER INFORMATION

FULL SERIES MENSTRUAL CYCLE HORMONE PROFILE

FOLLICULAR FUNCTION PROFILE (Pre-Peak Series)

☐ Day ___5___FSH* DATE/TIME DRAWN_____ INITIALS_____
☐ DAY_____ESTRADIOL* DATE/TIME DRAWN_____ INITIALS_____
☐ DAY_____ESTRADIOL* DATE/TIME DRAWN _____INITIALS_____
☐ DAY_____ESTRADIOL* DATE/TIME DRAWN_____ INITIALS_____
☐ DAY_____ESTRADIOL* DATE/TIME DRAWN_____ INITIALS_____
☐ DAY_____ESTRADIOL* DATE/TIME DRAWN_____ INITIALS_____
☐ DAY_____ESTRADIOL* DATE/TIME DRAWN _____INITIALS_____

Draw every other day through P+1 or P+2 then begin drawing Luteal Function Profile on P+3 if ordered

LUTEAL FUNCTION PROFILE (Post-Peak Series)

☐ PEAK +3* PROGESTERONE
ESTRADIOL DATE/TIME DRAWN_____ INITIALS____

☐ PEAK +5* PROGESTERONE
ESTRADIOL DATE/TIME DRAWN_____ INITIALS____

☐ PEAK +7** PROGESTERONE
ESTRADIOL DATE/TIME DRAWN_____ INITIALS____

☐ *Androstenedione* ☐ *Total Testosterone* ☐ *TSH* ☐ *FSH*
☐ *DHEA-SO4* ☐ *FT4* ☐ *LH*
☐ *SHBG* ☐ *T3* ☐ *Prolactin*
☐ *T4*

*REVERSE T3 SHOULD BE SENT TO YOUR LOCAL LAB FOR COMPLETE THYROID RESULTS

☐ PEAK + 9* PROGESTERONE
ESTRADIOL DATE/TIME DRAWN_____ INITIALS____

☐ PEAK +11* PROGESTERONE
ESTRADIOL DATE/TIME DRAWN_____ INITIALS____

DRAWING INSTRUCTIONS

*Submit minimum 1 mL serum aliquot in transfer tube from RED TOP OR SST for each day drawn. (DO NOT submit in SST) **Freeze all samples, keep until finished and ship together on ice packs.**
** *P+7 testing* requires two aliquots (**Minimum** One-1 mL, and One-2mL)

Prepaid shipping kits available.
Call 402-390-0532 to order a kit.

DIAGNOSIS

Diagnosis is MANDATORY for all Patient and Insurance Billing. Please circle the Diagnosis.

N93.9 Abnormal Uterine Bleeding
E28.1 Androgen Excess
N94.6 Dysmenorrhea
N93.8 Dysfunctional Uterine Bleeding
E34.9 Endocrine Receptor Disorder
R53.83 Fatigue, Other
N92.6 Irregular Cycles
E28.9 Luteal Phase Defect/Ovarian Dysf.
N92.0 Menorrhagia
E34.8 Other Endocrine Disorders
R10.2 Pelvic Pain
N94.3 PMS/PMDD
E28.2 Polycystic Ovarian Syndrome
E03.9 Hypothyroidism, NOS
E05.90 Hyperthyroidism, NOS
Z13.29 Thyroid Disorder Screening

ICD-10 Code_____
Diagnosis_____