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

PPVI Account #_____ *******NEW PATIENTS MUST SEND DEMOGRAPHIC INFORMATION FOR PROCESSING*******

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_____

□ LUTEAL FUNCTION PROFILE (Post-Peak Series) – Complete

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

PEAK +9 PROGESTERONE*
ESTRADIOL DATE/TIME DRAWN_____ INITIALS___

PEAK +11 PROGESTERONE*
ESTRADIOL DATE/TIME DRAWN_____ INITIALS___

DRAWING INSTRUCTIONS

Full Series Menstrual Cycle Profile:
Draw every other day through P+1 or P+2. On P+3 begin Drawing Luteal Function Profile if ordered.

*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 three aliquots (Two 1 mL, and One 2mL)

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

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

N93.9 Abnormal Uterine Bleeding
N93.8 Dysfunctional Uterine Bleeding
N92.6 Irregular Cycles
E28.9 Luteal Phase Defect/Ovarian Dysf.
N94.3 PMS/PMDD
E34.9 Endocrine Receptor Disorder
E34.8 Other Endocrine Disorders
E28.2 Polycystic Ovarian Syndrome
E28.1 Androgen Excess
EO3.9 Hypothyroidism, Unspecified
Z13.29 Thyroid Disorder Screening
ICD-10 Code_____
Diagnosis_____