

Anti-Müllerian Hormone (AMH) Test Request Form

Name: _____ Date of Birth: _____

Gender: _____ Email: _____ Phone Number: _____

Address: _____

Emergency Contact: _____ Relationship: _____

Medical History

- **Primary Care Physician:**
- **Referring Physician:**
- **Medical Conditions:**
- **Medications:**
- **Allergies:**

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:**
- **Sample Collection Time:**
- **Preferred Lab (if any):**

Physician's Notes

- **Reason for AMH Test:**

- **Clinical Indications:**

- **Additional Comments:**

Patient Signature:_____ **Date:**_____

Physician Information

- **Physician's Name:**
- **Medical License No.:**
- **Clinic/Hospital:**
- **Contact Number:**