



MEDICAL CENTER



PATIENT NAME: _____ DOB: _____

ADDRESS: _____ DATE: _____

R_x

To whom it may concern:

(*Patient Name*) is currently trying to have his semen evaluated and needs to purchase the Home Semen Analysis services. Two refills requested and granted. Please call with any questions.

PHYSICIAN SIGNATURE: _____ DATE: _____

REFIL 0 1 3 4 5 PRN