

GAIL N. JACKSON, M.D.  
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DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

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

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**LABS TEST REQUESTED:**

- **BASIC METABOLIC PANEL**
  - Glucose
  - Calcium
  - Sodium
  - Potassium
  - CO2
  - Chloride
  - BUN
  - Creatinine
- **LIPIDS PANEL/CHOLESTEROL PANEL**
  - Total Cholesterol
  - HDL
  - LDL
  - VLDL
  - LDL/HDL Ratio
- **HORMONE PANEL**
  - FSH
  - Estradiol
  - Testosterone
  - TSH
- **Hgb A1C**
- **RANDOM GLUCOSE**

**DX: V70.0**

**Thank You,**

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Gail N. Jackson, M.D.

