



# MEDICAL CENTER



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PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_

# R<sub>x</sub>

**To whom it may concern:**

**(Patient Name) is currently trying to get pregnant and needs to purchase the TYB and BioTranz for semen transport. Ten refills requested and granted. Please call with any questions.**

**PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

REFIL 0 1 3 4 5 PRN