Ref:

GP Name

Address 1

Address 2

Address 3

Postcode

Date

Dear

Patient Name

This letter is to inform you that the above patient has been assessed as being suitable for testosterone replacement therapy:

**Testosterone**: Form Dose

Frequency

Next review by consultant will be (date)

Next blood tests are due (as per Pan Mersey guideline) by secondary care 3 to 6 months after the commencement of treatment, approx. date

Baseline blood results were

As per the [Pan Mersey Area Prescribing Committee recommendation](https://www.panmerseyapc.nhs.uk/media/2258/testosterone.pdf), this medicine is categorised as AMBER Recommended and we would be grateful if you would agree to prescribe this treatment (and administer if injection preparation).

If you have any questions during the next few months until patient is seen again in clinic please contact the number below for advice. After the 6-month review is completed by the secondary care specialist, the dose may need adjustment and any relevant information will be communicated to you. The patient has been informed of the frequency of blood tests required and if patient fails to attend for secondary care blood test, one further appointment will be made, but thereafter you are advised to stop prescribing until the monitoring requirements have been met.

To acknowledge whether or not you agree to prescribe testosterone to your patient, please sign and return this letter to department within 14 days. Please retain a copy for your records.

Thank you

Yours sincerely

**Name**

Position

**To be completed by GP (\*delete as applicable)**

I agree/do not\* agree to prescribe testosterone to the above patient in accordance with Pan Mersey guideline for testosterone prescribing in men with androgen deficiency.

GP Signature Print Date