ADVANCED FERTILITY CARE

9819 N. 95th Street, Suite 105
Scottsdale, AZ 85258
Tel (480) 874-2229 | Fax (480) 874-2231
http://www.azfertility.com

REFERRAL REQUEST FORM

Date _____

Requesting Provider_____ NPI_____

Phone_____ Fax _____

Referring Physician Signature_____

Reason for Referral

Clinical Services:

- ☐ Consult for evaluation and treatment
- ☐ Consult for Fertility Preservation
- ☐ Consult for Donor Egg

Fertility Diagnostic Assessment:

- ☐ Hysterosalpingogram (HSG) – *schedule between days 5 and 13 of menstrual cycle*
- ☐ Post Sterilization Hysterosalpingogram (HSG) – *schedule between days 5 and 13 of menstrual cycle*
  - ☐ Previous Endometrial Ablation
- ☐ Sonohysterogram (SHG) - *schedule between days 5 and 13 of menstrual cycle*

Andrology Services:

- ☐ Complete Semen Analysis (2-7 days of sexual abstinence required)
- ☐ Semen Analysis and Urine Evaluation for Sperm (Retrograde Ejaculation)
- ☐ Post Vasectomy Analysis – MUST BE SCHEDULED ONLINE @ www.azfertility.com

Other:

- ☐ _____

Patient Information

Patient Name_____ DOB _____

Address_____Phone _____

Insurance _____ Member ID/Grp# _____

Spouse Information

Spouse Name_____ DOB _____

Phone (if known) _____

Insurance _____ Member ID/Grp# _____