UAB REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY
REFERRAL FORM FOR INFERTILITY AND FERTILITY PRESERVATION SERVICES

Referring Physician: ________________________ Physician Phone: ________________________

Patient Name: ________________________ Date of Birth: ____________ Phone: ________________

Address: ________________________ City, State, Zip: ________________________

INSURANCE:

Insurance Company Name: ________________________

Policy #: ____________ Group #: ____________

Name of Insured: ________________________

DIAGNOSES PROMPTING EVALUATION:

1. ________________________
2. ________________________
3. ________________________

☐ **REQUEST FOR GENERAL FERTILITY EVALUATION: (primary / secondary infertility)**

LMP: ________________ Parity: _____ (full term) _____ (preterm) _____ (aborted/miscarried) _____ (living) _____ (ectopic)

Duration of infertility: ________________

PLEASE INCLUDE COPIES OF BELOW LABS AND IMAGING PERFORMED

Prior laboratory testing:

☐ Semen analysis ☐ AMH ☐ TSH, Free T4 ☐ Blood Type and Screen ☐ CBC ☐ Prolactin
☐ Hemoglobin A1C ☐ Vit D ☐ HIV, Hep B, HCV AB, RPR ☐ Rubella IgG ☐ Varicella IgG

Prior imaging:

☐ Transvaginal ultrasound of uterus and ovaries including antral follicle count (AFC)
☐ Hysterosalpingogram (HSG)
☐ Saline sonogram (SIS)
☐ Other ________________________

Prior genetic testing: ________________ (i.e. carrier screening; Myriad / Counsyl)

Prior fertility therapies: ________________ (ovulation induction, insemination, in vitro fertilization)
Please include last clinic note

Prior surgeries: ________________________

☐ **REQUEST FOR FERTILITY PRESERVATION PATIENTS:**
(Oncofertility preservation prior to starting cancer treatment, egg freezing, sperm banking, lupron suppression, embryo freezing, fertility preservation prior to gender-affirming hormone therapy or surgery)

Diagnosis: ________________________ Date of diagnosis: ________________

Prior therapies: (surgery, chemotherapy, radiation) ________________________

Planned therapies: ________________________

Timeline for therapy initiation (when planned): ________________________

Fertility goals discussed with patient at time of diagnosis: ☐ Yes ☐ No ☐ Unsure

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WILL YOUR PATIENT REQUIRE SPECIAL ASSISTANCE DURING THE VISIT:
(please specify, i.e. wheelchair, interpreter)

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O'NEAL COMPREHENSIVE CANCER CENTER

UAB MEDICINE