Andrology Provider Referral Form

Center for Repoductive Medicine

Referring Physician *

First Name Last Name

Phone Number *

Area Code Phone Number

Fax Number *

Area Code Phone Number

Clinic Name *

Patient Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Patient Name *

First Name Last Name

Patient DOB *

Month Day Year

Patient Age

Partner Name *

First Name Last Name

Partner DOB *

Month Day Year

Partner Age

Diagnosis Code *

Individual Laboratory Procedures

Endocrine

- ☐ Anti-Mullerian Hormone
- ☐ ESD
- ☐ FSH
- ☐ B-HCG
- ☐ LH
- ☐ Progesterone
- ☐ Prolactin
- ☐ TSH

Preparation For Insemination

- ☐ Sperm Donor
- ☐ ICI-unwashed
- ☐ IUI-prewashed
- ☐ Density Gradient
- ☐ Sperm Wash-Partner
- ☐ Retrograde Wash

Microbiology

- ☐ Semen Culture
- ☐ Mycoplasma, PCR
- ☐ Ureaplasma, PCR

Cryopreservation

- ☐ Semen
- ☐ LTS > 60 days
- ☐ STS < 60 days
- ☐ Testicular Tissue Cryopreservation
- ☐ Sperm Test Thaw

Antibody Tests

- ☐ Antisperm antibody-Male
- ☐ Antisperm antibody-Female

Diagnostics Tests

- ☐ Semen Analysis
- ☐ Retrograde Analysis
- ☐ Post Vasectomy analysis-quantitative
- ☐ Sperm Penetration Assay
- ☐ Sperm Morphology
- ☐ Sperm Aneuploidy (through the University of Utah)
- ☐ Semen Fructose

Signature _____