

FERTILITY REFERRAL FORM



PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Last 4 SSN	Primary Language
Address		
City	State	ZIP
Email		
Home Phone	Work Phone	Cell Phone
Primary Contact Method (check one)	<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT	
Primary Caregiver/Alt Contact Name (if applicable)		
Caregiver/Alt Contact Email	Caregiver/Alt Contact Phone	

PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title
Preferred Contact Method (check one)	<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	Referral Contact Email
Office Phone	Office Fax	
Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name / Specialty		
Prescriber State License #		DEA #
NPI #		Medicaid UPIN #

INSURANCE INFORMATION

Insurance Provider	Plan ID #	
BIN#:	PCN#:	RX Group#:
Insured's Name	Relationship to Patient	

Eligible for Medicare (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list Medicare #
Prescription Card (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list carrier

Please include a copy of the front and back of insurance card.

CLINICAL INFORMATION

Prescription Type	<input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment	Therapy Start Date
		Continuation of Therapy - Date of Last Treatment
Allergies	<input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)	
Ship to Address	<input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)	

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Other/Concomitant Medications		
Check All That Apply <input type="checkbox"/> CRYO/AH <input type="checkbox"/> RECIPIENT (Egg Donation) <input type="checkbox"/> CRYO CYCLE <input type="checkbox"/> EGG DONOR <input type="checkbox"/> IVF <input type="checkbox"/> IUI (Partner) <input type="checkbox"/> ISCI/AH <input type="checkbox"/> IUI (Donor)		
ICD-10 Codes	<input type="checkbox"/> Code: _____ Description _____ <input type="checkbox"/> Date of Diagnosis ____/____/____	

We accept Escribe and fax prescriptions.

