Hysterosalpingogram (HSG) Referral

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MIDWEST Fertility Specialists

FAX: 317-571-9483
At The Surgery Center of Carmel
12188-A N. Meridian St., Suite 150
Carmel, IN 46032

FAX: 260-490-4319
At Inverness Surgery Center
8004 Carnegie Blvd.
Ft. Wayne, IN 46804

Please fax this completed form and a copy of the patient's insurance card, front and back, to the appropriate fax number listed above.

Date:_____ Physician Name (printed):_____

Physician Signature:_____

Patient's Legal Name:_____Date of birth:_____

Patient's Contact Phone:_____ SS #:_____

☐ **PLEASE PERFORM AN HSG ON MY PATIENT. DIAGNOSIS CODE** ***(Required)***:

☐ V26.21 (Fertility Testing) ☐ V26.51 (Tubal Ligation Status) ☐ V25.43 (Implantable Subdermal Contraceptive) ☐ Other:_____ (Specify Diagnosis Code)

☐ **A PRESCRIPTION FOR A PROPHYLACTIC ANTIBIOTIC HAS BEEN GIVEN TO HER.**
(Recommended: Doxycycline 100 mg BID x 3 days starting the day before HSG)

☐ **REQUEST FAXED REPORT TO FAX NUMBER:**_____

PATIENT DEMOGRAPHIC/INSURANCE/HEALTH INFORMATION (*Required*)

Patient Address:_____

City:_____State:_____ Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Age:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Insurance:_____ Policyholder Name:_____

Policyholder's Birthdate:_____Policy #:_____Policy Group #:_____

Policyholder's SS #:_____Provider/Member Services Phone: (___)_____

Height:_____Weight:_____Allergies:_____

Major Illness:_____

Present Medication(s):_____

_____

Previous Surgeries:_____

_____