AUDUBON FERTILITY REFERRAL FORM

Patient Information

Name: _____ DOB: _____
Phone: _____ Email: _____
Address: _____
Preferred Contact Method: ☐ Phone ☐ Email ☐ Other: _____

Referring Physician Information

Name: _____ Practice: _____
Phone: _____ FAX: _____
Email: _____

Physician being Referred to:

☐ Dr. Keith Isaacson ☐ Dr. Lindsay Wells ☐ First Available

Reason(s) for Referral/Diagnosis Code:

☐ Asherman's Syndrome, N85.6
☐ Uterine Fibroids, D25
☐ Adenomyosis, N80.03
☐ Uterine septum, Q51.22
☐ C/section isthmocele, O34.22
☐ Other _____
☐ Infertility, N97.0
☐ Recurrent pregnancy loss, N96
☐ Endometriosis, N80
☐ Fertility preservation, Z31.84
☐ Abnormal uterine bleeding, N93.9

Procedure(s) Recommended (if applicable):

☐ Hysteroscopic lysis of adhesions, 58559
☐ Laparoscopic myomectomy, 58546
☐ Abdominal myomectomy, 58146
☐ Hysteroscopic septum resection, 58560
☐ Hysteroscopic myomectomy, 58561
☐ Hysteroscopy w/Endometrial Biopsy, 58558
☐ Hysterosalpingogram (HSG)
☐ Other: _____
☐ Fertility Preservation
☐ Stain for plasma cells

Urgency of Referral:

☐ Routine ☐ Urgent (please specify): _____

Please have any pertinent records or notes emailed to us at info@audubonfertility.com.

I confirm that I am referring this patient to the above physician at Audubon Fertility for evaluation and care.

_____ _____
Signature **Date**