

**INFERTILITY REFERRAL**

*(Please provide all details. Incomplete forms will not be accepted)*

<b>Date</b>	<b>Medical record No.</b>	
<b>Name (Wife):</b>	Date of Birth:	Nationality:
<b>Husband's Name</b>	Date of Birth:	Nationality:

<b>Parity</b>	<b>Infertility duration:</b>	<b>No. of Living children</b> (current marriage):
<b>Wt</b>	<b>Ht</b>	<b>BMI</b>
<b>No. of Previous IVF Attempts:</b>		

<b>Hormones</b> (Cycle day 2/3. Must be within last 3 months)			Date:	
FSH:	LH:	E2:	Prolactin:	TSH

<b>HSG*</b> (Please attach report)	Date
------------------------------------	------

<b>Laparoscopy*</b> (Please attach report)	Date
--	------

*\*(Tubal status must be checked except in cases of severe male factor etiology)*

<b>Rubella</b>	Immune [ ]	Non-immune [ ]	Date:
<b>Cervical smear</b>	Normal [ ]	Abnormal [ ]	Date:

<b>Semen Analysis</b>	Date	Date
Volume		
Count		
Motility (Grade 1&2)		
Morphology		
Other		

<b>Diagnosis</b>					
Ovulatory [ ]	Male [ ]	Multiple [ ]			
Tubal [ ]	Unexplained [ ]	Other [ ]			

**Other information** (e.g. any relevant medical/surgical history. Please attach a separate report if required)

<b>Referring Doctor</b>	<b>Telephone No</b>
<b>Hospital</b>	<b>Fax</b>
<b>Signature</b>	<b>Stamp</b>