مستشفى الملك فيصل التخصّصي ومركز الأبحاث

KING FAISAL SPECIALIST HOSPITAL & RESEARCH CENTRE

تعليمات هامة للمريض: تعبئة البيانات التالية من قِبَل الطبيب المُعالج (خارج المستشفى)

This form will be reviewed only if completely filled and stamped

Date: / /

INFERTILITY REFERRAL FORM

Name (*Female*) .....
Age: .....
Nationality: .....
Med. Rec. No: .....
Duration of Infertility: .....

Name (*Male*): .....
Age: .....
Nationality: .....
Med. Rec. No: .....

No. of preg. ..... No. of deliveries: ..... No. of Abortions ..... No. of Ectopics .....
No. of living children as a couple (from the current marriage) .....
Cycle ..... (regular/irregular/oligo-amenorrhea) .....

Female: FSH ..... LH ..... TEST ..... PROLACTIN .....
TSH ..... F14 ..... (early follicular phase)
HSG ..... (normal/abnormal/not done) Date: .....
(Attach copy of report, if done) : Yes, bilateral tubal block
Laparoscopy ..... (normal/abnormal/not done) Date: .....
(Attach copy of report, if done)

Diagnosis. 1. .....
2. .....
3. .....
.....

Date: .....

Male: **Semen Analysis**

Volume: .....
Count/ml: .....
Motility: .....
Morphology: .....

FSH ..... LH ..... TEST ..... PROLACTIN .....
Testicular biopsy: ..... (not done/normal/abnormal) Date: .....
(In case of azoospermia (*Attach copy of report, if done*).
Clinical Examination: Specify abnormalities: .....
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Diagnosis: 1. .....
2. .....
3. .....

Comments: .....
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Name of Treating Doctor

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