



UNC Fertility

REFERRAL FORM

To make a referral: Please provide the information below and then fax this form and any other pertinent records to us at (919)596-6147.

Your patient can call the toll free number below to schedule the appointment, or you can call on your patient's behalf.
Please provide your patient with a copy of this form including our directions on the back.

- Marc Fritz, M.D.
 Jennifer Mersereau, M.D., MSCI
 Matt Coward, M.D.
(Male Reproductive Specialist)
 Steven Young, M.D., PhD
 Mary Peavey, M.D., MSCI
 Linnea R. Goodman, MD
 No Preference

Patient name: _____ Phone: _____ Date of Birth: _____

Referring physician: _____ Fax reports back to: _____

Please fax any pertinent records about this referral to UNC Fertility at (919) 596-6147

Evaluation For New Patients:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Egg Donation | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Preimplantation Genetic Diagnosis (PGD) | <input type="checkbox"/> Tubal Anastomosis |
| <input type="checkbox"/> Egg Freezing | <input type="checkbox"/> Mullerian Anomaly | <input type="checkbox"/> Premature Ovarian Failure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Myomas/Myomectomy | <input type="checkbox"/> Recurrent Pregnancy Loss | _____ |
| <input type="checkbox"/> Gestational Surrogacy | <input type="checkbox"/> Ovarian Cystectomy | <input type="checkbox"/> Reproductive Endocrine Disorders | |
| <input type="checkbox"/> Hysteroscopy | <input type="checkbox"/> Polycystic Ovary Syndrome (PCOS) | | |
| <input type="checkbox"/> Hysterosalpingogram (HSG) | | | |
| <input type="checkbox"/> In Vitro Fertilization (IVF) | | | |

Male Fertility Evaluation:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abnormal Semen Analysis | <input type="checkbox"/> Sperm Extraction | <input type="checkbox"/> Erectile and Ejaculatory Dysfunction |
| <input type="checkbox"/> Azoospermia ("Zero Sperm Count") | <input type="checkbox"/> Electroejaculation | <input type="checkbox"/> Fertility Preservation |
| <input type="checkbox"/> Vasectomy Reversal | <input type="checkbox"/> Varicocele | <input type="checkbox"/> Hypogonadism (Low testosterone) |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Hormonal and Genetic Evaluation | <input type="checkbox"/> Other _____ |

Andrology Services Requested:

- Semen Analysis (sperm density, progressive motility, and strict morphology)
 Sperm Cryopreservation (Banking)
 Urine Evaluation for Retrograde Ejaculation

*Note: UNC Fertility has contracts with most payers and will provide a complimentary insurance verification prior to a patient's appointment. Covered members are subject to their Copay / Deductible only.

PATIENT SCHEDULING (919) 908-0000

UNCfertility.com • 7920 ACC BLVD • Suite 300 • Raleigh, NC 27617