



# OREGON HEALTH & SCIENCE UNIVERSITY

## FERTILITY CONSULTANTS ANDROLOGY/EMBRYOLOGY LABORATORY

Center for Health & Healing  
3303 SW Bond Avenue, Mail Code: CH10F  
Portland, OR 97239-4501

**PLEASE COMPLETE THIS INFORMATION. IT IS REQUIRED BY YOUR INSURANCE CARRIER IN ORDER TO BILL FOR SERVICES. THANK YOU.**

What condition are you being seen for today? \_\_\_\_\_

\_\_\_\_\_

When did this illness or condition start? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_   $\checkmark$  here if exact date is unknown.  
Month Day Year

Date of your last menstrual period. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Name & Address of Referring Provider: \_\_\_\_\_

\_\_\_\_\_

Name & Address of Primary Care Provider (if different): \_\_\_\_\_

\_\_\_\_\_

ANOTHER referral source ( $\checkmark$ ):  Web search  Telephone pages  Family/Friend  Insurance Co.

Other (specify) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THANK YOU FOR YOUR HELP WITH OUR EFFORTS TO BETTER SERVE OUR PATIENTS.**

**(For physicians use only)**

Date of onset of similar/related illness: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_   $\checkmark$  here if exact date is unknown.  
Month Day Year

Letter dictated on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year