



Patient Referral Form

Baton Rouge: (225) 926-6886 Lafayette: (337) 989-8795 www.fertilityanswers.com

Patient name: _____

DOB: _____ Patient phone #: _____ Date LMP: _____

Referring physician: _____

Referring physician phone # _____ fax #: _____

Reason for Referral (check all that apply):

- HSG
- SA
- AMH
- Triple Test (HSG+SA+AMH)
- Consult – Infertility
- Consult – Endometriosis
- Consult – Fibroids
- Consult – RPL
- Consult – Other: _____

Location:

Fertility Answers Baton Rouge, 500 Rue de la Vie, Suite 510, Baton Rouge 70817
FAX: (225) 922-3730

Fertility Answers Lafayette, 206 E. Farrel Road, Lafayette 70508
FAX: (337) 989-8766

Physician Signature: _____ Date: _____

Physician: Please fax this form to the appropriate office fax number above and give the referral form to the patient.

Patient: Your physician has referred you to Fertility Answers. Please call (225) 926-6886 (Baton Rouge clinic) or (337) 989-8795 (Lafayette clinic) to schedule your appointment. Please bring this referral form with you to the office.