Texas Children's Hospital | Pavilion for Women

# REQUEST FOR REPRODUCTIVE ENDOCRINOLOGY AND FERTILITY SERVICES

Baylor College of Medicine — DEPARTMENT OF OBSTETRICS & GYNECOLOGY

**Today's Date: _____**

**SECTIONS 1 – 4 MUST BE COMPLETED FOR THIS REFERRAL FORM TO BE PROCESSED.**

## 1. LOCATION:

Texas Children's Pavilion for Women, Family Fertility Center
6651 Main Street, Ste. E350 Houston, TX 77030
P: 832-826-7500 F: 832-825-9413

## 2. REASON(S) FOR VISIT: Choose all that apply

| | | |
|---|---|---|
| ☐ Infertility (IVF, ISCI) | ☐ Fertility Preservation | ☐ Recurrent Pregnancy Loss |
| ☐ Fibroids | ☐ Family Planning | ☐ Other _____ |
| ☐ Male Infertility | ☐ Premature Ovarian Failure | |
| ☐ PCOS | ☐ Endometriosis | |

## 3. PATIENT AND REFERRING INFORMATION: ALL FIELDS ARE REQUIRED. INCOMPLETE FORMS WILL DELAY SCHEDULING.

| | | | | |
|---|---|---|---|---|
| Patient Name: | | DOB: | | |
| Address: | | City: | ST: | Zip: |
| Home#: | Cell #: | Work#: | | |
| Emergency contact and phone #: | | | | |
| Email: | | Interpreter needed? ☐ Yes ☐ No Language? | | |
| Referring Provider: | | | | |
| Address: | | City: | ST: | Zip: |
| Phone#: | Fax#: | Nurse/Contact: | | |

## 4. INSURANCE: MUST INCLUDE COPY OF INSURANCE CARD

| | |
|---|---|
| Primary Insured: ☐ Self ☐ Other | Name of Insurance:_____ |
| _____ | Group #: _____ |
| DOB: _____ | ID#: _____ |

## ADDITIONAL INFORMATION: