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**Referral Form (Female Patients)**

**Please fax to 423-643-0699 - Include Patient Profile, Medical Records and Insurance Card**

Date of Referral: \_\_\_\_\_ Name of Referring Provider: \_\_\_\_\_

Referring Provider Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Please Print

Patient Name (Female) : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Phone Number(s): ( ) \_\_\_\_\_ / ( ) \_\_\_\_\_

Patient (Female) Email Address: \_\_\_\_\_  
 Email address must be on file for registration and consents

Patient Home Address: \_\_\_\_\_

Patient City, State, Zip: \_\_\_\_\_

Spouse/Partner of: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 (if applicable)

**Patient Insurance Information: TRM participates in most major carriers but not Medicare, Medicaid or TN Care.**

**Service(s) Requested (REQUIRED):**

- Consult
- \* Hysterosalpingogram (HSG) – please see note below about results vs. counseling option
- \* Saline Sonogram (SIS) – please see note below about results vs. counseling option
- \*If HSG/SIS only requested, patient will get results but not counseling about treatment; counseling will be done by referring provider.
- \*If counseling by TRM is desired, please mark “Consult” as well.

**Semen Analysis** – If female’s spouse/partner is being referred for Semen Analysis, please complete S/A Referral Form.

**Referral Information (REQUIRED):**

<u>Fertility</u>	<u>ICD-10</u>	<u>Uterine Abnormality/Pelvic Pain</u>	<u>ICD-10</u>
<input type="checkbox"/> Anovulatory Infertility	N97.0	<input type="checkbox"/> Heavy or Frequent Menses	N92.0
<input type="checkbox"/> Tubal Factor Infertility	N97.1	<input type="checkbox"/> Scant or Infrequent Menses	N91.5
<input type="checkbox"/> Female Factor Infertility	N97.8	<input type="checkbox"/> Fibroids or Polyps	D25.1 or N84.0
<input type="checkbox"/> Diminished Ovarian Reserve	E28.39	<input type="checkbox"/> Endometriosis	N71.9
<input type="checkbox"/> Female Unexplained Infertility	N97.9	<input type="checkbox"/> Intrauterine Adhesions	N85.6
<input type="checkbox"/> Fertility Preservation			

**Endocrine**

- PCOS E28.2
- Hirsutism L68.0
- Menopausal Symptoms N95.1
- Elevated Prolactin E22.1

**Other:** Please specify with description and ICD-10

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**Once order and demographic information are received, patient will receive email to complete electronic consents. Once consents are complete, patient may contact TRM to schedule appointment.**