TRM TENNESSEE REPRODUCTIVE MEDICINE
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Referral Form (Semen Analysis)

PLEASE COMPLETE AND FAX TO 423-643-0699
ALONG WITH PATIENT PROFILE & COPY OF INSURANCE CARD

Date of Referral: _____

Name of Referring Provider: _____
Please Print

Signature of Referring Provider: _____

Referring Provider Phone: (___) _____ Fax: (___) _____

Patient Name (Male) :_____ Date of Birth: _____

Patient Phone Number(s):___(___) _____ / (___) _____

Patient (Male) 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: Please send a copy of patient's insurance card with order. TRM participates in most major carriers but does not participate in Medicare, Medicaid or TN Care programs.

Referral Information

Diagnosis (REQUIRED)
- □ Male Infertilty (N46.9)
- □ Hypogonadism (E29.1)
- □ Fertility Testing (Z31.41)
- □ Azoospermia (N46.0)
- □ Organic Azoospermia (N46.01)
- □ Scrotal Varices/Varicocele (I86.1)
- □ Vasectomy (Z30.2)
- □ Stricture of Vas Def (N50.89)

Test Requested (REQUIRED)
- □ Semen analysis with Strict Morphology, CPT 89322
- □ Semen analysis - Retrograde, CPT 89331
- □ Sperm freeze, CPT 89259, 89320, 89343, 89260/89261
- □ Post Vasectomy Analysis, CPT 89320
  _____ Date of Vasectomy (Analysis 3 mos. Post Surgery)
- □ Post Vas REVERSAL Analysis, CPT 89320/89322
  _____ Date of Reversal (Analysis 6 wks & 3 mos. Post Surgery)

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.