Center for Advanced Reproductive Services a first fertility center

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Request for Sperm Test

By appointment only (at home testing may be available)
Please call 860-321-7082 or 860-525-8283 to discuss locations/options for testing

Patient Name: _____ DOB: _____ Patient Phone: _____

Referring Physician Name: _____ NPI Number: _____

Physician Address: _____

Physician Phone: _____ Physician Fax: _____

Physician Email: _____

Please indicate the diagnosis and procedure requested:

Diagnosis:

____ Azoospermia N46.01 ____ Varicocele I86.1 ____ Oligospermia N46.11

____ Male Infertility - Unspecified Origin N46.9 ____ Vasectomy Z98.52

____ Other: _____

Test:

____ Comprehensive semen analysis ___ Count and motility only ___ Mesa ___ Tesa

____ Cryopreservation of sperm ____ Cryopreservation of testicular tissue

____ Other: _____

*Insurance Company: _____ *Ins. ID Number: _____

*Group Number: _____ *Ins. Auth Number (if applicable):_____

Physician's Signature: _____ Date: _____

Name of Referred's Spouse or Partner: _____

Additional Comments: _____

_____

_____

***If insurance info/auth is incomplete, or if the physician's signature isn't included, the appointment may not be rendered and/or billed to insurance.**

All referrals are to be faxed to 860-838-6481

PLEASE BE SURE ALL AREAS ARE COMPLETED BEFORE FAXING