Center for Advanced Reproductive Services | a first fertility center

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Fertility Patient Referral Form

All **referrals** are to be **faxed** to one of the numbers below

Date of Referral: _____

Fax #: 860-838-6481 **Farmington Office** - 2 Batterson Park Road, Farmington, CT 06032
Phone #: 844-467-3483

Fax #: 860-525-1930 **Hartford Office** - 50 Columbus Boulevard, Hartford, CT 06106
Phone #: 860-525-8283

Fax #: 203-481-1708 **Branford Office** - 6 Business Park Drive, Suite 304, Branford, CT 06405
Phone #: 203-481-1707

Fax #: 860-838-6481 **Middlebury Office** - 751 Straits Turnpike, Suite 1S, Middlebury, CT 06762
Phone #: 475-305-0714

Fax #: 860-525-1930 **Springfield Office** - 3550 Main Street, Suite 203, Springfield, MA 01107
Phone #: 413-683-0014

Fax #: 800-861-7125 **Danbury Office** - 73 Sand Pit Road, Suite 203, Danbury, CT 06810
Phone #: 203-702-6723

Referring Physician: _____

Physician Phone #: _____ Physician Fax #: _____

Patient Name: _____ DOB: _____

Do you wish us to contact your patient for an appointment? Yes | No
(circle one)

Patient Phone #: _____ Times to call: _____

Patient being referred for the following reason: IVF | Infertility | Egg Freeze | Other
(circle one)

If other, please explain: _____

_____

_____

PROHIBITION ON REDISCLOSURE: This information has been disclosed from records whose confidentiality is protected by Federal and State law. Regulations prohibit making any further disclosure of this information except without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this offense and not more than $500.00 in the case of the first offense and not more than $500.00 in the case of each subsequent offense.

PLEASE BE SURE ALL AREAS ARE COMPLETED BEFORE FAXING