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	☐ Tubal Reversal
☐ Male Infertility	☐ Premature Ovarian Failure	☐ Perimenopause
☐ PCOS	☐ Endometriosis	☐ Other _____

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: