ORM FERTILITY

Physician Andrology Order

Patient Name(Female): ______________________ **DOB:** ______________

Spouse/Partner Name(Male): ______________________ **DOB:** ______________

Patient Telephone Number: ______________ **Spouse/Partner Telephone Number:** ______________

NOTE: Prior Authorization may be required for these services. Please contact the patient's insurance company to initiate & follow up with your patient, if necessary.

Sperm Testing

☐ **Semen Analysis**

Pre-Chemotherapy Patients ONLY

☐ **Sperm Freeze**
PRN up to (date of chemo/radiation)
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☐ **Communicable Disease Panel**
(required for storage of sperm)

Insemination

☐ **Intrauterine Insemination(s)**

- **Planned number of inseminations:** ________
- **PRN up to (date)** __________

NOTE: Patients will have same day access to their results via the ORM patient portal. By submitting this signed order, you acknowledge this and that ORM assumes no responsibility of providing the patient with result interpretation.

Referring Physician Information:

Physician or Clinic Name: ____

Address: ____

Telephone: ______________________ **Fax Number:** ______________________

Physician Signature: ______________________________ **Date:** ______________

Physician NPI Number: ______________________ (needed for Sperm Freeze & Communicable Disease Panel)

****PATIENTS MUST CONTACT ORM TO SCHEDULE SEMEN COLLECTION/DROP-OFF****
TO SCHEDULE, PLEASE CALL 503.274.4994 (Option 1)

****ORDERS EXPIRE IN 6 MONTHS****

Please fax order & patient demographics to (503) 274-4946

For more information about IVF pregnancy success rates: www.SART.org
www.ormfertility.com