Andrology Services Form

Patient Information

Patient Name _____ DOB _____ /_____ /_____

Phone _____ Email _____

Preferred Prounouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

Sex Assigned at Birth ☐ Male ☐ Female ☐ Intersex ☐ N/A

Partner Name (if applicable) _____ DOB _____ /_____ /_____

Phone _____ Email _____

Preferred Prounouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

Sex Assigned at Birth ☐ Female ☐ Male ☐ Intersex ☐ N/A

Andrology Services (Under care of referring provider | No ORM consultation required)

(ORM Fertility is not responsible for interpretation of andrology results)

☐ Semen Analysis

☐ IUI (Intrauterine Insemination) (Procedure Only)
*Order is good for 6 months from original order date

☐ Fertility Preservation (Sperm Freezing) (with communicable disease testing)
Ordering Provider NPI _____
*Order is good for 6 months from original order date

Patient must contact ORM at 503.274.4994 (Opt. 1 + Opt. 2) to schedule Andrology Services

Referring Provider

Provider Name _____ Provider Signature _____

Clinic Name _____

Phone _____

Fax _____

Please email this form to providerreferrals@ormfertility.com or fax to 503.274.4946

For information on our referral program, incentives and provider resources, visit ormfertility.com/forproviders

Download the digital form at ormfertility.com/forms

ORM FERTILITY

For Patients

We look forward to connecting with you!

You've been referred to ORM Fertility by your provider.

Please call 503.274.4994 (Option 1) to schedule your appointment.

ORM FERTILITY