

# Hysterosalpingogram Referral Services



**Seattle Reproductive Medicine®**

A N I N T E G R A M E D® A F F I L I A T E

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Patient Name: \_\_\_\_\_ Patient Phone: \_\_\_\_\_ Date: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

Referring MD Name: \_\_\_\_\_  Request fax report (Fax Number: \_\_\_\_\_)

*Referral*

Please perform an HSG on my patient.

*Antibiotics*

My patient was given prophylactic antibiotics. Please note that unless indicated, the performing SRM physician will prescribe antibiotics, as medically indicated, following the results.

Please provide the following information to help us take care of your patients:

Gravidity \_\_\_\_\_ Parity \_\_\_\_\_ Age \_\_\_\_\_ Allergic to iodine/shellfish  Yes  No If yes, what is the reaction \_\_\_\_\_

Medical problems \_\_\_\_\_

Previous Surgery \_\_\_\_\_

What question are you looking to get answered?

Tubes open?  Uterine cavity normal?  Other, please detail \_\_\_\_\_

**Referring Office Instructions:** Please fax referral request to SRM 206-285-4555

**Patient:** Please call SRM to schedule HSG and bring copy of referral with you to exam

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**Appointments 1-877-777-6002 Fax: 1-206-285-4555**

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