

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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