

Dear Dr. _____,

Clinic name: _____ Clinic Fax: _____ Clinic Phone: _____

Patient: I, _____, (Date of Birth _____) am in the process of scheduling a consultation at the Emory Reproductive Center. Please forward all copies of any tests /procedures listed below done on me at your office.

Signature

Date

Patient Phone Number

Partner: I, _____, (Date of Birth _____) am in the process of scheduling a consultation at the Emory Reproductive Center. Please forward all copies of any tests /procedures listed below done on me at your office.

Signature

Date

Partner Phone Number

Please be sure to include any records pertaining to my infertility. They should include the following:

- Diagnostic Fertility Testing (HSG & SHG– images and reports, semen analyses, ovarian reserve)
- Laboratory results
- Pathology results
- Operative reports (particularly pelvic or gynecologic surgeries)
- Pap smear and cervical culture reports
- Treatment cycles (IUI, IVF)
- Embryology Reports
- Clinic note

Please forward these records to:

**Emory Reproductive Center
ATTN: Medical Records
550 Peachtree Street, NE
Medical Office Tower, Suite 1800
Atlanta, GA 30308
Phone: 404-778-3401, # 1
Fax: 404-686-4956**