Fertility Enrollment Form

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6 Simple steps to submitting a referral

1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐Male ☐Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐Office ☐ Other: _____

☐ 628 Female Infertility ☐ Other: _____

Height: _____ Weight: _____ Allergies: _____ Has patient received injection training? ☐ Yes ☐ No

Has patient tried and failed Clomiphene Citrate? ☐ Yes ☐ No If yes, how many cycles did patient complete? _____

Anticipated Start Date: _____

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Ganirelix Acetate	250mcg/0.5ml syringe				☐ Low Dose HCG				
☐ Cetrotide	☐ 0.25mg kit ☐ 3mg kit				☐ Insulin Syringe	0.5cc			
☐ Leuprolide Acetate	2-week kit				☐ Progesterone in oil	50mg/ml vial			
☐ Microdose Leuprolide	50mcg/0.1ml 10ml vial				☐ Progesterone in Cottonseed oil	50mg/ml vial			
☐ Insulin Syringe	0.5cc				☐ Progesterone in Olive oil	50mg/ml vial			
☐ Bravelle	75 unit vial				☐ 3cc 18g 1.5" Syringe, 22g 1.5" Needle				
☐ Menopur	75 unit vial				☐ Progesterone	_____mg caps			
☐ Repronex	75 unit vial				☐ Progesterone Suppositories	_____mg			
☐ Q-Cap IM (3cc syringe only, 25g 1.5" needle)					☐ Crinone 8%	15 appl (26.1GM)			
☐ Q-Cap SubQ (3cc syringe only, 27g 0.5" needle)					☐ Endometrin	100mg			
☐ Follistim	75 unit AQ vial				☐ Vivelle Dot	_____mg patches			
☐ Follistim	150 unit AQ vial				☐ Estradiol	_____mg tabs			
☐ Follistim	300 unit AQ Cartridge				☐ Femtrace	_____mg			
☐ Follistim	600 unit AQ Cartridge				☐ Clomiphene Citrate	50mg tabs			
☐ Follistim	900 unit AQ Cartridge				☐ Methylprednisolone	_____mg			
☐ Follistim Pen					☐ Doxycycline	100mg tabs			
☐ Gonal-f RFF	75 unit vial				☐ Baby Aspirin	81mg tabs			
☐ Gonal-f RFF	300 unit pen				☐ Birth Control				
☐ Gonal-f RFF	450 unit pen				☐ Prenatal Vitamin				
☐ Gonal-f RFF	900 unit pen				☐ Folic Acid	1mg tabs			
☐ Gonal-f RFF	450 unit MDV				☐ IM (3cc22g1.5" syringe, 25g 1.5" needle)				
☐ Gonal-f RFF	1050 unit MDV				☐ SubQ (3cc22g1.5" syringe, 27g 0.5"needle)				
☐ HCG	10,000 unit vial				☐				
☐ Novarel	10,000 unit vial				☐				
☐ Ovidrel	250mcg syringe				☐ Sharps container				
☐ Pregnyl	10,000 unit vial				☐ Patient Edu.				

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

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PHYSICIAN SIGNATURE REQUIRED

X _____
DISPENSE AS WRITTEN (Date)

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)