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|  | Dr. Carolyn KaplanREPRODUCTIVE ENDOCRINOLOGY & INFERTILITY GROUP3193 Howell Mill Rd, Suite 209, Atlanta, GA 30327Phone: 404-370-1817Fax: 404-591-8909 |

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am in the process of scheduling a consultation with REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY GROUP. Please forward the information listed below ASAP to Dr. Carolyn Kaplan at fax 404-591-8909.

1. Semen Analysis
2. Hysterosalpingogram reports and films or discs
3. Endometrial biopsy reports
4. Hormonal assays such testosterone, prolactin, progesterone, estradiol, LH, FSH and/or thyroid profiles
5. STI tests done for both the patient and Partner/Spouse

By initialing here \_\_\_\_\_\_ (Self) \_\_\_\_\_ (Spouse) I authorize the release of HIV/AIDs testing results to be faxed to Dr. Kaplan.

1. Pap Smear and/or cervical cultures
2. Any Genetic testing including but not limited to chromosome testing, karyotyping, and pathology from pregnancy losses.
3. Pap smear and/or cervical cultures
4. Any Treatment Cycle Notes (IUI, TIC, IVF)

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| NameSignatureSocial Security NumberDate | Partner/Spouse NamePartner/Spouse SignaturePartner/Spouse Social Security NumberDate |