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A Professional Association.

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Board Certified Reproductive Endocrinologists  
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Licensed Psychologist

## Hysterosalpingogram (HSG) Requisition

Please fax to **817-545-2164** Attn: Michelle Giosio

Patient Name \_\_\_\_\_  
(please print)

Patient DOB \_\_\_\_\_

Patient Contact Number \_\_\_\_\_

Patient Secondary Contact Number \_\_\_\_\_

Please Check HSG Type:

\_\_\_\_\_ Infertility, Female (unspecified) **DX 628.9**

\_\_\_\_\_ Procreative Management Fertility Testing **V26.21**

\_\_\_\_\_ Aftercare following sterilization reversal **V26.22**

\_\_\_\_\_ Permanent Sterilization Confirmation Test **V67.09**

\_\_\_\_\_ Date of Procedure

Was depo shot administered at time of procedure?

\_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_ Menorrhagia (pre-ablation evaluation) **DX 626.2**

Choose location:

\_\_\_\_\_ Bedford

\_\_\_\_\_ Frisco

Referring Physician \_\_\_\_\_  
(please print)

Referring Physician Signature \_\_\_\_\_

Additional Comments: \_\_\_\_\_

*To expedite the scheduling process, please also fax a demographic sheet and insurance information for the patient.*