INSTRUCTIONS FOR HYSTEROSALPINGOGRAPH (HSG) AND/OR TUBAL CANNULATION REFERING PHYSICIAN PATIENTS

1. Call between 9:00 am and 4:00 pm Monday-Friday to schedule your HSG. This procedure must be scheduled between days 5-10 of your menstrual cycle.

2. The HSG will be performed in our SOMERSET OFFICE (81 Veronica Avenue in Somerset).

3. No intercourse from day 1 of your period until the completion of the HSG.

4. You MUST obtain a prescription for an antibiotic (Vibramycin 100 mg/Doxycycline 100mg). You will be taking one tablet twice a day for five days starting the day before the procedure. (10 tablets)

5. Take (4) Advil or Motrin for a total of 800 mg one hour before the procedure.

6. If you have had an HSG previously, obtain a copy of your films prior to the procedure.

7. Please arrive 15 minute prior to the procedure to the SOMERSET OFFICE (81 Veronica Avenue).

8. Upon arrival to the Somerset office the nurse will do a urine pregnancy test before the HSG is performed.

9. IMPORTANT: If a referral is required it is your responsibility to bring the referral the day of the procedure. If you do not have a referral we will not be able to perform the procedure.

10. Please read and sign the “Notice of Privacy Practices” and bring in with you the day of your appointment.

PROTOCOL FOR ASTHMATICS AND PATIENTS ALLERGIC TO X-RAY CONTRAST

1. If you have a history of asthma or are allergic to x-ray contrast you MUST let your physician know so you can obtain a prescription for PREDNISONE 20 mg. The prednisone is to be taken as follows: (6 tablets)
   - 2 tablets – the morning the day before the exam
   - 2 tablets – the evening the day before the exam.
   - 2 tablets – the morning of the exam.

2. A patient is considered “allergic” if, at an earlier date, she developed any of the following symptoms from IV contrast – sneezing, nasal congestion, hives, chest tightness, breathing difficulty, sensation of a lump in the throat, wheezing or diffuse redness of the skin.
IMPORTANT INFORMATION

Dear patient:

Please fax your insurance card both front and back, as soon as possible.
Please include the following:

1. Patient’s Name
2. Patient’s date of birth
3. Patient’s Social Security number.
4. Policy holders (1) Name (2) date of birth (3) social security number.

Fax to: (732) 545-1164

If we do not have the above information prior to your appointment you may be responsible for payment on the day of your visit.

Please Note:

Some insurance plans require a referral and/or pre-authorization. It is your responsibility to bring the referral and/or the pre-authorization to your appointment. Failure to do so may result in you being responsible for full payment on the date of service.

If you have any questions regarding billing please contact our billing department.

BILLING DEPARTMENT

732-545-1186

Authorization and Benefits Ext. 619
OUTSIDE HSG

POST ESSURE HSG

Patient’s Name _______________________________ Date of Birth __________

Social Security Number ___________ - ___________ - ___________

Address __________________________________________________

________________________________________________________________

Home Phone ______________________ Work Phone ______________________

Appointment Date _________________ Appointment Time_______________

Physician referring you to IVF NJ ____________________________
(First and Last Name)

_________________________________________________________________

Type of appointment HSG - (HYSTEROSALPINGOGRAM)

Physician patient is seeing ________________________________

Date information packet mailed out ________________________


INSURANCE INFORMATION

Insurance Company (PATIENT) ______________________________________

ID # ________________________________ Group _______________________

Subscriber’s Name __________________________

Customer Service # ________________________