CENTER FOR ASSISTED REPRODUCTION EMBRYO.NET™
A Professional Association

1701 Park Place Ave.
Bedford, TX 76022
(817) 540-1157

1250 8th Ave Ste 365
Fort Worth, TX 76104
(817)924-1572

Hysterosalpingogram (HSG) Requisition
Please fax to 817-545-2164 Attn: Jill Caccese

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 _____
Type of Procedure: Adiana_____ Essure_____
Was depo shot administered at time of procedure?
_____ Yes _____ No **Start date of depo** _____

_____ Medicaid Permanent Sterilization Confirmation Test **V26.51 and V25.49**
Date of Procedure _____
Type of Procedure: Adiana_____ Essure_____
Was depo shot administered at time of procedure?
_____ Yes _____ No **Start date of depo** _____

_____ Menorrhagia (pre-ablation evaluation) **DX 626.2**

Choose location:

_____ Bedford

_____ Fort Worth

Referring Physician_____
(please print)

Referring Physician Signature_____

Referring Physician Fax #_____

Additional Comments: _____
To expedite the scheduling process, please also fax a demographic sheet and insurance information for the patient.

_____ I would like a CARE physician to call the patient to discuss results.

_____ I prefer to discuss the test results with the patient. Please do not call them.