School of Medicine

Department of Obstetrics & Gynecology

Division of Reproductive Endocrinology & Infertility

Fertility Consultants
Center for Health & Healing, CH10F
3303 SW Bond Avenue, 10th Floor
Portland, OR 97239-4501

CLINIC
503-418-4500 (In Portland)
855-230-4500 (Toll Free)

FAX
503 418-3708

www.fertilityoregon.com

Phillip E. Patton, M.D.
Professor & Director

Paula Amato, M.D.
Associate Professor

David M. Lee, M.D.
Associate Professor

Diana H. Wu, M.D.
Assistant Professor

David E. Battaglia, Ph.D., HCLD
Associate Professor
Director, Andrology/Embryology Lab

▶ Please PRINT all information except where a signature is indicated ◀

DATE: ______________________

PATIENT NAME:

____

(Last) **(First)** **(MI)**

DOB: _____________ **SSN**_______________________

is currently under my care. She has had a normal Pap smear within the last year.

TYPE OF INSEMINATION:

❒ Husband/Partner Insemination
- Name of Husband/Partner:

  ____

  (Last) **(First)**

❒ Donor Insemination

I AUTHORIZE:

Oregon Health & Science University, Fertility Consultants, Center for Health & Healing, CH10F, 3303 SW Bond Avenue, 10th Floor, Portland, OR 97239-4501. Phone: 503-418-4500 (In Portland); 855-230-4500 (Toll Free); FAX: 503-418-3708

to do up to 6-cycles of inseminations after which the patient will then be sent back to me for re-evaluation. I realize OHSU will only be performing the insemination and that the patient will be referred back to me with any questions regarding her fertility treatment.

▶ The patient will need to register with OHSU as soon as possible by telephoning (503) 494-8505 ◀

Must be signed by an M.D. or D.O. ______________________________
(Physician's Signature)

Physician Information: ______________________________
(Printed Name)

____
(Street Address)

____
(City, State, Zip Code)

____
(Phone) **(FAX)**

▶ RETURN THIS AUTHORIZATION TO OHSU FERTILITY CONSULTANTS ◀