



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
o 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