مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre
Gen. Org. مؤسسة عامة

تعليمات هامة للمريض: تعبئة البيانات التاليـــة من قبل الطبيب المُعالج (خارج المستشفى)

This form will be reviewed only if completely filled and stamped

Date: / /

INFERTILITY REFERRAL FORM

Name (*Female*) ..... Name (*Male*) .....
Age: ..... Age: .....
Nationality: ..... Nationality: .....
Med. Rec. No: ..... Med. Rec. No: .....
Duration of Infertility: .....

No of preg..... No of Deliveries ..... No of abortions..... No of Ectopics.....
No of living children as a couple (from the current marriage) .....
Cycle.....(regular / irregular / oligo-amenorrhea) .....

Female: FSH ..... LH ..... TEST ..... PROLACTIN .....
TSH ..... FT4 ..... (early follicular phase)
HSG ..... (normal / abnormal / not done) Date .....
(*attached copy of report, if done*): Yes, bilateral tubal block
Laparoscopy..... (normal / abnormal / not done) Date .....
(*attached copy of report if done*)

Diagnosis:
1. .....
2. .....
3. .....
.....

Male: **Semen Analysis** Date.....
Volume: .....
Count/ml: .....
Motility: .....
Morphology: .....

FSH ..... LH ..... TEST ..... PROLACTIN .....
Testicular biopsy: ..... (normal / abnormal / not done) Date.....
In case of azoospermia (*attached copy of report, if done*)
Clinical Examination: Specify abnormalities: .....
.....

Diagnosis:
1. .....
2. .....
3. .....

Comments: .....
.....

Name of Treating Doctor:
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Main/Ellg فورم سيف