SPRING FERTILITY

Fertility Consult Referral

newpatients@springfertility.com
p. (971) 429-6000

Portland Clinic / Lab

2055 NW Savier St. Ste 150
Portland, OR 97209

Note To Patient: *Please bring your ID and insurance information. Note that payment will be due at time of service.*

Patient Name _____

Email _____

Phone _____ **D.O.B.** _____

CONSULTATION (choose one):

- ☐ Infertility Consult
- ☐ LGBTQ+
- ☐ Reproductive Mental Health Counseling
- ☐ Fertility Preservation
- ☐ Single Parent by Choice
- ☐ Genetic Counselor

Referring Physician _____

Physician Signature _____

Office Phone _____

All results sent via fax.

Office Fax Number _____

Please email this form to newpatients@springfertility.com or fax to (415) 877-1879.

COMMENTS:

Know your options.