



## Semen Analysis Referral

newpatients@springfertility.com  
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## New York City Clinic / Lab

114 W 41st Street, 2nd Floor  
New York, NY 10036

**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. \_\_\_\_\_

Referring Physician \_\_\_\_\_

Physician Signature \_\_\_\_\_

Office Phone \_\_\_\_\_

*All results sent via fax.*

Office Fax Number \_\_\_\_\_

Partner Name to Reference \_\_\_\_\_

### SPECIFIC SERVICES:

Semen Analysis (Routine)

IUI Wash

Semen Analysis (Strict Morphology)

### COMMENTS:

**Know your options.**

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