



## Semen Analysis 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. \_\_\_\_\_

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

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

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

*All results sent via fax.*

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

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

### SPECIFIC SERVICES:

Semen Analysis (Strict Morphology)

### COMMENTS:

**Know your options.**

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