



Where Families Blossom

Referral Form

Jeremy Groll, MD
Fertility Specialist

Phone: (937) 458-5084 Fax: (937) 458-5089

Email: appointments@SpringCreekFertility.com

Thank you for referring your patient to SCF for a consult. We appreciate your confidence and trust.

Date of request: _____

Please call the patient so that they may Schedule a consultation

Please call the physician's office to Schedule an appointment on the patient's behalf

Physician requesting consultation: _____

Telephone: _____ Fax: _____

Patient Name: _____ DOB: _____

Telephone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Ins: _____ Secondary Ins: _____

Subscriber: _____ Subscriber: _____

Subscriber DOB: _____ Subscriber DOB: _____

ID#: _____ ID#: _____

Telephone: _____ Telephone: _____

Subscriber Employer: _____ Subscriber Employer: _____

Please fax (937) 458-5089 or email appointments@SpringCreekFertility.com this form to us with the **patients' fertility treatment records**. Examples of information that might assist us in helping your patients include:

- HSG or Saline Sonogram Results
- Endocrine Testing
- Partner Semen Analysis and Male Screening
- Fertility Treatment Records (including flow sheets)
- Operative Reports

Thank you for the referral. We appreciate participating in your patients fertility care!

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