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South Perth WA 6151
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Patient Name: _____

Date of Birth: _____ Telephone: _____

Address: _____

Medicare: _____ Ref: _____ Exp: _____

EXAMINATION REQUEST

- | | | |
|---|---|--|
| <input type="checkbox"/> Pelvic US – Initial Scan | <input type="checkbox"/> Early Pregnancy US | <input type="checkbox"/> Saline Sonography |
| <input type="checkbox"/> Pelvic US – Follow Up | <input type="checkbox"/> Viability Scan | <input type="checkbox"/> HyCoSy |
| <input type="checkbox"/> Pelvic US – Antral Follicle Count | | <input type="checkbox"/> Testicular US |
| <input type="checkbox"/> Pelvic US – Deep Infiltrating Endometriosis (advanced gynaecological assessment) | | |

CLINICAL DETAILS:

FERTILITY WORK UP DAY 5-10 OF CYCLE

? PELVIC PATHOLOGY ? ANTRAL FOLLICLE COUNT

DOCTOR DETAILS

Name: _____

Provider No: _____ Telephone: _____

Address: _____

Doctor Signature: _____ Date Requested: _____

REPORT DELIVERY

- | | |
|---|------------------------------|
| <input type="checkbox"/> Healthlink | <input type="checkbox"/> Fax |
| <input type="checkbox"/> Email (please specify) | |
| <input type="checkbox"/> Copies to: | |

