The Reproductive Medicine Group
The Prelude Network®

OUT OF TOWN MONITORING ORDERS
FAX ORDERS PRIOR TO SCHEDULING APPOINTMENT

Thank you for referring your patient to The Reproductive Medicine Group. So that we may provide the appropriate service or testing requested, it is important to provide us with the following information: **date of referral**, **patient first and last name, date of birth, diagnosis** for the service requested, the **Ordering Physician's name** and **office location** and **fax number** to send our findings to you.

If your patient will require more than one visit to our practice, the patient will need a consult with one of our physicians before monitoring services can be performed.

If your facility is going to be financially responsible for the patient's medical services, we will need the attached Credit Card Authorization form to be signed by the person financially responsible for payment of services. **Please fax the completed, signed Credit Card Authorization form to our billing office at (813) 676-8812.**

Patient Name: _____ **Patient DOB**:_____

Ordering Physician: _____ **Physician Signature**: _____

Facility Name: _____ **Facility Contact:** _____

Facility Phone Number: (____) _____ **Fax Number to send results**: (____) _____

Date To be Performed: _____

Please select the orders to be performed. Please remember to indicate the corresponding diagnosis:

☐ Labwork: ☐ Stat

- ☐ Stat ☐ Estradiol (E2)
- ☐ Stat ☐ FSH
- ☐ Stat ☐ LH
- ☐ Stat ☐ Progesterone (P4)
- ☐ Stat ☐ Beta hCG, quant.
- ☐ Stat ☐ Other: _____

Diagnosis to use for requested labs:

- ☐ Z31.83 - Encounter for assisted reproductive fertility procedure
- ☐ Z31.84 - Encounter for fertility preservation procedure
- ☐ Z52.810 – Anonymous Egg Donor
- ☐ Z52.89 – Organ Tissue Donor (Gestational Surrogate)
- ☐ Z32.00 – Encounter for pregnancy test unconfirmed
- ☐ Z32.01 – Pregnancy test, positive result

☐ Transvaginal Ultrasound Monitoring: ☐ Stat

- ☐ Follicle Count and Size
- ☐ Endometrial Thickness and Pattern
- ☐ Abnormalities:

_____

Diagnosis to use for requested procedure:

- ☐ Z31.83 - Encounter for assisted reproductive fertility procedure
- ☐ Z31.84 - Encounter for fertility preservation procedure
- ☐ Z52.810 – Anonymous Egg Donor
- ☐ Z52.89 – Organ Tissue Donor (Gestational Surrogate)

☐ Saline Infusion Sonogram: ☐ Stat

- ☐ N97.0- Infertility Anovulation
- ☐ N97.1- Infertility Tubal Origin
- ☐ N97.2- Infertility Uterine Origin
- ☐ N97.9- Infertility Unexplained
- ☐ N97.1- Infertility Other

Diagnosis to use for requested procedure:

- ☐ Z31.81 - Male factor infertility in female patient
- ☐ N96 - Recurrent Pregnancy Loss
- ☐ Z52.810 – Anonymous Egg Donor
- ☐ Z52.89 – Organ Tissue Donor (Gestational Surrogate)
- ☐ Other: _____

PLEASE CALL ONE OF OUR OFFICES LISTED BELOW TO SCHEDULE AN APPOINTMENT

☐ 5245 East Fletcher Ave
Suite 1
Tampa, FL 33617
Phone: 813.914.7304
Fax: 813.914.7314

☐ 612 Medical Care Dr
Brandon, FL 33511
Phone:813.914.7304
Fax: 813.914.7314

☐ 2919 Swann Ave
Suite 305
Tampa, FL 33609
Phone:813.914.7304
Fax: 813.914.7314

☐ 3165 McMullen Booth Rd
Suite F-2
Clearwater, FL 33761
Phone: 813.914.7304
Fax: 813.914.7314

☐ 3743 Maryweather Ln
Suite 101
Wesley Chapel, FL 33544
Phone: 813.914.7304
Fax: 813.914.7314

Revised: 9/19/2025