Northwestern Medicine®

Fertility and Reproductive Medicine

HSG REQUEST FORM

Patient name: _____

Patient contact phone number_____

Patient DOB:_____

Referring physician name:_____

Referring physician preferred contact information:_____

Referring physician fax number:_____

HSG indication:

☐ Infertility or recurrent pregnancy loss / ☐ other, describe:

_____

_____

Potential concerns:

☐ none OR

- ☐ Contrast allergy
- ☐ History of PID
- ☐ History of tubal disease or ectopic pregnancy
- ☐ Previous abdominal or pelvic surgery
- ☐ other

Describe any potential concerns below:

_____

_____

_____

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Please fax this form to the Lavette Pattison in the Division of Fertility and Reproductive Medicine, (f) 312-695-4924, or email to hsg@nm.org. Our patient representatives will contact the patient to schedule the procedure and provide instructions. The results will be faxed back to you after the HSG is performed.