

*Board Certified in Reproductive Endocrinology and Infertility Board Certified in Obstetrics and Gynecology

Outside REMOTE MONITORING ORDERS Tests performed by appointment only

Ordering Physician's Name Physician Signature				Practice Name Address			
Date:							
Patient Name:				Date of Birth:			
Diagnosis/Diagno	sis Code:			_SS#:			
Please perform the	following ul	trasound on					
☐ Vaginal v		or follicular de	evelopment and endometric	ll thickness (Endometrial linin	g	mm)
 ☐ 6500 N. Mopac Bldg. I, Ste 1200, Austin, Texas 78731; ☐ 16040 Park Valley Drive, Bldg. I, Ste 201, Round Rock, Texas 78681 ☐ 18707 Hardy Oak Drive, Suite 505, San Antonio, Texas 78258 ☐ 705 Generations Drive, Suite 102, New Braunfels, Texas 78130 				Phone (512)451-0149 ext. 7459; Fax (512)451-0977 Phone (512)451-0149 ext. 7459; Fax (512)451-0977 Phone (210) 370-3800; Fax (210) 370-3005 Phone (830)608-8004; Fax (830) 620-9077			
RIGHT OVARY			<u>LEFT O</u>	<u>VARY</u>			
1		·	mm	1	mm		mm
2			mm		mm		mm
3			mm		mm		mm
4			mm		mm		mm
5			mm		mm		mm
6	mm	12	mm	6	mm	12	mm

Please note Texas Fertility Center does not draw labs or give lab orders to monitor patients. If labs are needed the patient can be drawn at local Clinical Pathology draw station or at LabCorp.

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