CCRM FERTILITY HOUSTON

Medical Record List

If you have previously completed any of the tests or treatments below, please send us a copy of your medical records at least 72 hours prior to your first appointment. Your medical history helps your physician develop a custom-tailored treatment plan to ensure you have the best outcome possible. Note: a medical records release form is available at the end of this list.

You can upload these records through our clinical portal, which can be accessed at: www.ccrmivf.com/patientportal/. If you have any questions before your appointment, please contact our office at **(713) 465-1211**.

CATEGORY	TESTS
PRIOR TESTING RECORDS	
Ovarian Reserve Testing	• Anti-Mullerian hormone (AMH) • Day 3 FSH, Estradiol (E2) • Antral Follicle Testing
Hormone Testing	• Thyroid stimulating hormone (TSH) • Free Thyroxine (Free T4) • Prolactin
Infectious Diseases	• HIV • Hepatitis B • Hepatitis C • Syphillis • HTLV I/II (patients using donor sperm, donor egg) • CMV (patients using donor sperm, donor egg)
Uterine Cavity Evaluation	• Hysterosalpingogram (HSG) • Hysteroscopy • Femvue • HycoSy • Sonohysterogram
Recurrent Pregnancy Loss	• Anti Cardiolipin Antibody • Lupus Anticoagulant • Beta 2 Glycoprotein • Karyotype (female and male)

CATEGORY	TESTS
Genetic Testing	Examples may include: Individual testing such as Cystic Fibrosis (CF), Spinal Muscular Atrophy (SMA), Tay Sachs Large scale genetic testing (testing of multiple disorders at once) e.g. Good Start, Counsyl Karyotype
Male Testing	Semen Analysis Infectious Diseases (see above)
Polycystic Ovarian Syndrome	• Total Testosterone • Free Testosterone • Sex Hormone Binding Globulin (SHBG) • 17-OH-Progesterone • Hemoglobin A1C • 2 hour Oral Glucose Tolerance Test • Fasting Lipids (e.g. total cholesterol, low density lipoprotein [LDL], high density lipoprotein [HDL], Triglycerides)
PRIOR TREATMENT RECORDS	
Intrauterine Insemination (IUI)	• Stimulation medication (Clomid, Letrozole, Gonal F, Follistim) • Stimulation flow sheet (follicle sizes, hormone levels) • IUI sperm sample (concentration, the number of total motile sperm)

IVF Cycles	• Stimulation Flow Sheet (follicle size and hormone levels) • Egg sheet with fertilization sheet (type of insemination [regular insemination, ICSI] number of eggs aspirated and the number that fertilized) • Embryo sheet (stage, grading) • Embryos transferred (number transferred/stage/grade) • Cryopreservation (number and stage of embryos frozen) • Additional testing results (PGD/PGS)
OTHER PHYSICIAN VISIT NOTES	
Fertility Related Notes	Initial consult visit note
	First visit note after testing completed
	Most recent visit note

MEDICAL RECORDS TO CCRM HOUSTON[1]
(From Other Physicians)

In determining your care and treatment with CCRM Houston, our providers want to have a complete understanding of any past related care you and/or your partner have received from other physicians.

Following this page is a medical record release form for your use in requesting your records from your previous doctor(s).

Given medical record releases can take many weeks to process and to insure CCRM Houston receives your records in time, please submit this form to your doctor as soon as possible and have the records sent directly to CCRM Houston. **If you have a partner, he/she will need to complete a separate release form.**

Indicate the date of your CCRM Houston appointment on your form in the corresponding field.

Records must be received no less than three business days before your appointment.

[1] Houston IVF, PA and Houston IVF Management Company, LP

AUTHORIZATION TO RELEASE MY MEDICAL RECORDS TO CCRM HOUSTON[2]

Patient Name:_____ Date of Birth: _____

CCRM Houston Appointment Date:_____

I hereby authorize:

Person/Organization:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

To release the following medical records (check all that apply):

- ☐ All medical records, meaning every page in my record, including but not limited to: consult notes, ultrasound reports, operative reports, pap smear pathology report, semen analysis, pathology report, last IVF/IUI cycle records, HSG, mammogram radiology)
- ☐ All laboratory tests and results
- ☐ All imaging tests and results
- ☐ Other: _____

Unless stated otherwise in the section below, I understand the information referenced above may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health, or drug or alcohol use.

- ☐ I authorize the release or disclosure of only:_____
- ☐ I do not authorize the release or disclosure of this type of information

Records should be sent to:

CCRM Houston
Texas Medical Center
7400 Fannin
Suite 910
Houston, TX 77054
Fax: (713) 255-0510

CCRM Houston
Memorial City
929 Gessner
Suite 2300
Houston, TX 77024
Fax: (713) 550-1475

CCRM Houston
Sugar Land
16545 SW Freeway
Suite 200
Sugar Land, TX 77479
Fax: (218) 302-5659

This authorization ends: ☐ upon fulfillment of this request, OR ☐ on this date_____ , OR ☐ is enforced until written notice is given by me indicating a termination of this authorization

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

_____

Patient or Legally-Authorized Individual Signature Date

_____

Printed Name of Signee Relationship (self, parent, guardian, etc.)

[2] Houston IVF, PA and Houston IVF Management Company, LP