

Tubal Reversal Arrangements

Thank you for your interest in tubal reversal. Typical success rates for this procedure are 90-95%.

If you are interested in having me perform your surgery, please send the following to our office:

1. A printed and completed patient information form.
2. A copy of your operative report and/or pathology report from your tubal ligation.
3. \$75 is required to cover administration costs for review of your medical records and history. This fee can be remitted either by check or money order or by phone via your MasterCard or Visa.

Please send these items to:

The Infertility Center of Saint Louis
224 S. Woods Mill Road, Suite 730
Saint Louis, Missouri USA 63017

Forms may be faxed to (314) 576-1442.

We can be reached by phone at (314) 576-1400 or by email at silber@infertile.com.

PATIENT INFORMATION FOR TUBAL RECONSTRUCTION

(please print or type)

Date _____

Name _____ Birthdate _____ Age _____

Mailing Address _____
(street) (city) (state) (zip)

Home Address _____
(street) (city) (state) (zip)

Home Tel. # _____ Social Security # _____

Cell # _____

Business Tel. # _____ Marital Status: Single Engaged Married

Email Address _____

Occupation _____ Employer _____

Husband/Fiance's Name _____ Birthdate _____ Age _____

Cell # _____

Work # _____

Occupation _____ Employer _____

Health Insurance Co. _____ Effective Date _____

Group # _____ ID/Member# _____ Coverage Code _____

Referred by: _____ Telephone # _____

1. Have you ever had any children? _____ If so, how many? _____
Has your husband/fiance ever had any children? _____ If so, how many? _____
If not, has your husband/fiance had a semen analysis performed? _____ If your husband/fiance has not fathered a child previously, a semen analysis must be done and results received and reviewed by the doctor prior to scheduling surgery. (attach test results if performed)
2. What was the cause of your tubal obstruction? Tubal ligation? Other? _____
If tubal ligation, when was the procedure performed? _____
3. Were there any previous attempts at reconstruction of tubes? _____
If so, how many _____ When? _____
4. Why do you want a tubal reconstruction now? _____
5. When were you last seen by a doctor for a physical examination? _____
Is your health generally good? _____ If you have any health problems, please indicate on attached medical history form.
6. When was the date of your last pap smear? _____ (attach test results)
7. When was the date of your last pelvic exam? _____ (attach test results)
8. When was the date of your last breast exam/mammogram? _____ (attach test results)

MEDICAL HISTORY

(please print or type)

Name _____

Date _____

A. Height _____ Weight _____

B. Past Medical History

1. Have you ever had any of the following illnesses?

- a. heart disease _____
- b. diabetes _____
- c. tuberculosis _____
- d. cancer _____
- e. infectious diseases other than colds or "flu" _____
- f. hepatitis _____ if so, when and how contracted _____
- g. sexually transmitted diseases? _____ when? _____ how treated? _____
- h. frequent colds _____
- i. ulcers _____
- j. bowel problems _____
- k. high blood pressure _____
- l. bleeding disorder _____
- m. asthma or other lung disease _____
- n. urinary problems _____
- o. other _____

2. List all past hospitalizations and/or operations _____

3. Do you have any allergies? Please list:

- a. to foods _____
- b. to drugs or medication _____
- c. other _____

4. Are you following a special diet? If so, what? _____

5. List all medications or drugs you are taking. State how often and the reason for taking them _____

6. Do you use tobacco? Please list:

- a. cigarettes _____ How much? _____ How long? _____
- b. cigars _____ How much? _____ How long? _____
- c. other _____ How much? _____ How long? _____

7. Do you drink alcoholic beverages? _____ How much? _____ How long? _____

SURGERY SCHEDULING PREFERENCE

Patient's Name _____ Date _____

Please carefully answer the questions below. With this information, we will make every effort to meet your personal request. In addition, you are welcome to call the office at any time regarding your appointment.

1. When would you prefer to have your surgery? _____

2. When will you NOT be able to come for your surgery?
() Not applicable. I can come anytime.
() I cannot come (give specific dates): _____

3. How much advance notice will you need in order to make arrangements for coming here?
() 2 days () 1 week () 2 weeks () 3 weeks
() 1 month () 2 months () 3 months
() other: _____

4. Where can you be reached by telephone during daytime hours to arrange your surgery date?

Telephone Number
(area code + number)

If I am not in, you can talk with
Name Relationship to you

a) _____
b) _____
c) _____

5. My Patient Information Forms
() have been sent to you already.
() are enclosed.

6. Please detail any other information about your personal situation or scheduling that might be helpful in our understanding your needs.

