Date: [Insert Date]

To: [Referring Physician Name]
Address: [Clinic/Hospital Address]
Fax/Phone: [Contact Information]

RE: Comprehensive Fertility Assessment

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Partner Name (if applicable): [Partner Name]

Dear Dr. [Physician Last Name],

Thank you for referring [Patient Name] for a comprehensive gynecological fertility assessment. I saw the patient on [Date] to evaluate their reproductive health and discuss their goals for conception.

Clinical History:
The patient reports attempting conception for [Number] months/years. Pertinent history includes [Insert History: e.g., regular/irregular menses, prior pregnancies, known conditions like PCOS or endometriosis, relevant surgeries].

Assessment and Findings:

- **Ovarian Reserve Testing:** [AMH levels, Day 3 FSH/Estradiol results, or Antral Follicle Count]
- **Uterine and Tubal Evaluation:** [Summary of Pelvic Ultrasound, HSG, or Saline Infusion Sonogram findings]
- **Ovulatory Function:** [Confirmation of ovulation via tracking or progesterone levels]
- **Partner Factors:** [Summary of Semen Analysis, if applicable]

Impression:
[Insert Diagnosis/Impression, e.g., Unexplained infertility, Diminished ovarian reserve, Tubal factor, etc.]

Recommendations and Plan:

1. [Recommendation 1: e.g., Lifestyle modifications/supplements]
2. [Recommendation 2: e.g., Ovulation induction with Letrozole/Clomid]
3. [Recommendation 3: e.g., Referral for IUI or IVF consultation]
4. [Recommendation 4: e.g., Follow-up imaging or repeat labs]

We have discussed the risks, benefits, and expected outcomes of the proposed plan. The patient is eager to proceed with [Selected Treatment].

I will keep you updated on their progress. Please do not hesitate to contact my office if you have any questions regarding this assessment.

Sincerely,

[Doctor Signature]
[Doctor Name, Credentials]
[Practice Name]
[Contact Information]