Date: [Insert Date]

To: [Referring Physician Name]
Clinic: [Referring Clinic Name]
Address: [Clinic Address]

RE: Diagnostic Gynecology Fertility Assessment

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Health Number: [ID Number]

Dear Dr. [Physician Last Name],

Thank you for referring [Patient Name] for a diagnostic fertility assessment. I saw the patient on [Date of Consultation] to evaluate their reproductive health and fertility potential.

Clinical History:
The patient reports [Number] years of infertility. Menstrual cycles are [Regular/Irregular] with a cycle length of [Number] days. Relevant medical history includes [Medical Conditions/Prior Surgeries].

Assessment and Findings:

- **Ovarian Reserve:** AMH levels: [Value], Day 3 FSH: [Value], Antral Follicle Count: [Value].
- **Uterine Evaluation:** [Pelvic Ultrasound/Sonohysterogram] findings: [Normal/Fibroids/Polyps/Arcuate].
- **Tubal Patency:** [HSG/HyCoSy] results indicate [Bilateral Patency/Blockage].
- **Partner/Sperm Analysis:** [Normal Parameters/Abnormalities Noted/Not Applicable].

Impression:
[Insert Diagnosis, e.g., Unexplained Infertility, PCOS, Diminished Ovarian Reserve, Tubal Factor].

Plan:
Based on the diagnostic findings, the following management plan has been discussed:
1. [e.g., Ovulation Induction]
2. [e.g., Referral for IVF/IUI]
3. [e.g., Lifestyle Modifications or Surgical Intervention]

I will follow up with the patient on [Date/Timeframe]. Please feel free to contact my office if you have any questions regarding this assessment.

Sincerely,

[Signature]
[Consulting Gynecologist Name]
[Credentials]
[Clinic Name/Department]