FERTILITY REFERRAL FORM
FAX COMPLETED FORM TO:
289-891-9591

PATIENT INFORMATION

Apply patient sticker or complete the following:
Last name ________________________ First name ________________
Date of birth (DD/MM/YYYY) ________________________________
Health card number ________________________________
Telephone ____________________ Alternate number ________________

REFERRING PHYSICIAN

Physician Name________________________________
Telephone ____________________ Fax ________________________
OHIP billing number ____________ CPSO license number ________________

REASON FOR REFERRAL

Fertility

- ☐ Fertility evaluation/counseling/treatment
- ☐ Anti-Mullerian Hormone (determination of ovarian reserve)
- ☐ Sonohysterograms (evaluation of uterine cavity and tubal patency)
- ☐ Ovarian stimulation
- ☐ Cycle monitoring
- ☐ Intra-uterine insemination (IUI)
- ☐ In-Vitro Fertilization (IVF)
- ☐ Egg donation
- ☐ Sperm donation / Donor sperm insemination
- ☐ Surrogacy
- ☐ Pre-implantation Genetic Diagnostic and screening
- ☐ Recurrent miscarriage
- ☐ Egg Freezing
- ☐ Other ____

Please attach all relevant test results and consultation reports.

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