Referral Form

PATIENT INFORMATION

Female Name ______________________________ Date of Birth ______________
Surname First name yy mm dd

Home Ph: ( ) ______________ Work Ph: ( ) ______________ Cell Ph: ( ) ______________

Personal Health Numbers: ______________ Partner: ______________

Partner's Name ______________________________ Date of Birth ______________
Surname First name yy mm dd

Address (Required) ______________________________
Postal Code

Referring Doctor ______________________________ Prac ID ______________
Surname First name

Office Phone No: ( ) Office Fax No: ( ) ______________

Office Address: ______________________________
Postal Code

Clinic Name: ______________________________

Does this patient speak and understand English? ☐ Yes ☐ No If no, please advise patient to bring an interpreter to the appointment.

Referrals will be triaged to the earliest available appointment.

☐ Unexplained Infertility ☐ Male Factor Infertility ☐ Recurrent Pregnancy Loss
☐ Egg Freezing ☐ Sperm Freezing Donor Gamete (egg or sperm)

☐ Other (Please explain) ______________________________

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Duration of unprotected intercourse? ☐ <1Yr ☐ 1-3Yrs ☐ 5Yrs

Previous Fertility Treatment? ☐ Yes ☐ No

Supporting Documentation (Please include any copies of any infertility testing done)

Physician signature: ______________________________

*Please note: Most fertility investigations are cycle time specific and will be requested at the patient's initial consultation appointment. *