REFERRAL FORM

Please fax completed form to 403-284-9293.

Referring Physician ________________________________ PRAC ID __________________

Office Address ____
street city province postal code

Office Phone ___________________________ Office Fax ____________________________

PATIENT INFORMATION: Please include name, DOB, PHN, and contact information.

Patient:	Partner (if applicable):

Referral will be triaged to the earliest available appointment for one of the following physicians:

Dr. S. Foong Dr. J. Min Dr. J. O'Keane Dr. N. Paterson Dr. S. Scott Dr. B. Wong

REASON FOR REFERRAL (check all that apply)

- ☐ In Vitro Fertilization (IVF)
- ☐ Male Factor Infertility
- ☐ Previous Vasectomy
- ☐ Previous Tubal Ligation
- ☐ Ovulation Induction
- ☐ Unexplained Infertility
- ☐ Recurrent Pregnancy Loss
- ☐ Pre-implantation Genetic Diagnosis
- ☐ Donor Insemination
- ☐ Donor Oocyte
- ☐ Surrogacy
- ☐ Fertility Preservation

SUPPORTING DOCUMENTATION (Please include copies of the following investigations if done)

Female Partner

- ☐ Hysterosalpingogram / sonohysterogram
- ☐ Pelvic ultrasound
- ☐ Day 3 FSH and estradiol
- ☐ Luteal phase progesterone
- ☐ Rubella titre
- ☐ Blood group, Rh factor, antibody screen
- ☐ Any gynecological surgery reports
- ☐ Previous IVF cycle records (stimulation sheet and embryology records)

Male Partner

- ☐ Semen analysis and anti-sperm antibodies

Comments: ____________________________________

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Physician signature: ____________________________________

#400, 2000 Veterans Place N.W., Calgary, Alberta T3B 4N2 TEL: (403) 284-5444 FAX: (403) 284-9293
www.regionalfertilityprogram.ca