REFERRAL FORM

REGIONAL FERTILITY PROGRAM

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. T. Gotz Dr. J. Hilton Dr. J. Min Dr. N. Paterson Dr. N. Raguz 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
- ☐ Preimplantation Genetic Testing
- ☐ Donor Sperm
- ☐ Donor Egg
- ☐ Surrogacy
- ☐ Fertility Preservation

SUPPORTING DOCUMENTATION

Please include copies of the following investigations if applicable:

Investigations

- ☐ Hysterosalpingogram / Sonohysterogram
- ☐ Pelvic ultrasound
- ☐ Anti-Mullerian Hormone
- ☐ 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)
- ☐ Semen analysis and anti-sperm antibodies

Comment: _____

Physician signature: _____

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www.regionalfertilityprogram.ca