Patient Referral Form

generation fertility

PATIENT LABEL (INTENDED CARRIER) / PARTNER LABEL [IF APPLICABLE SPERM / EGG PROVIDER]

Today's Date DD MM YYYY

Referring Physician

Name

OHIP billing number

Street Address

City

Province

Phone

Fax

E-mail

Patient Information

Name

Date of Birth DD MM YYYY

OHIP - - -

Expiry Date DD MM YYYY

Phone

E-mail

Biological / Assigned Sex

☐ Female ☐ Male ☐ Specify _____

☐ **URGENT:** Oncology or other medically necessary fertility preservation

Please attach all notes / reports. Patient will be contacted within 24 hours.

Preferred Pronouns

☐ She/Her ☐ He/Him ☐ They/Them ☐ Specify _____

☐ **BMI > 40**

Referring Information (for oncology patients)

Diagnosis:

☐ Chemotherapy ☐ Surgery

☐ Radiation Therapy ☐ Treatment completed

Reason(s) for referral

☐ In Vitro Fertilization

☐ Intrauterine Insemination

☐ Recurrent Pregnancy Loss

☐ Fertility Counselling

☐ Donor Egg / Sperm

☐ Surrogacy

☐ Egg / Sperm / Embryo Freezing

☐ Unexplained Infertility

Referral to

Waterloo (Dr. Judith Campanaro, MD, FRCSC) ☐

Serving other locations

Vaughan ☐

Newmarket ☐

Toronto West ☐

Fax or email completed forms to requested clinic location.
Thank you for entrusting us with your patient's care.

Waterloo
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