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

☐ **URGENT:** Oncology or other medically necessary fertility preservation
Please attach all notes / reports. Patient will be contacted within 24 hours.

☐ **BMI > 40**

Biological / Assigned Sex

☐ Female ☐ Male

☐ Specify _____

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

	Vaughan	Newmarket	Toronto West
First available specialist	☐	☐	☐
Dr. Tamara Abraham, MD, MSc, FRCSC, GREI	☐	☐	
Dr. David Gurau, MD, FRCSC, GREI	☐	☐	
Dr. Michael Hartman, MD, FRCSC, GREI	☐	☐	
Dr. Ingrid Lai, MSc, MD, FRCSC, GREI	☐	☐	
Dr. David Scholl, MD, FRCSC, GREI	☐	☐	
Dr. Violetta Buduryan, MD, FACOG			☐

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

Vaughan
955 Major Mackenzie Drive West, Suite 400
Vaughan, ON L6A 4P9
T: 289.357.0100
F: 289.357.0101
info@generationfertility.ca

Newmarket
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Newmarket, ON L3Y 9E5
T: 905.967.0852
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info@generationfertility.ca

Toronto West
56 Aberfoyle Crescent #300
Toronto, ON M8X 2W4.
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