PATIENT REFERRAL

Fax to: 416-506-0600

Email: referrals@triofertility.com

Attn: NEW PATIENT COORDINATOR

Patient Information:

Affix patient label if possible

Name:
Address: Email:
OHIP #:
DOB Phone:

Reason for Referral

☐ Trying unsuccessfully ☐ PCOS ☐ Endometriosis ☐ Donor Egg

☐ Recurrent loss ☐ Genetics ☐ Male factor ☐ Other_____

Has this patient been seen by TRIO before? Y N

Has this patient undergone fertility investigations or treatment before? Y N

If yes, please attach any relevant information or list below. Patient will be asked to bring all relevant and current test results to their initial consultation.

ADDITIONAL INFORMATION:

_____

_____

_____

The information you have provided will assist in determining which physician is the best suited for your patient's needs. They will see one of the following doctors. If you have a preference, please indicate.

☐ Dr. Kaajal Abrol ☐ Dr. Ken Cadesky ☐ Dr. Robert Casper ☐ Dr. Paul Chang
☐ Dr. Beth Gunn ☐ Dr. Michael Hartman ☐ Dr. Carl Laskin ☐ Dr. Dan Nayot
☐ Dr. Judith Perry ☐ Dr. Sony Sierra

Referring Physician Signature: _____

Billing #:_____ Fax: _____

PRINT Name: _____

Patients will be contacted within 2 business days with an appointment date.

ADVANCING REPRODUCTIVE CARE

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triofertility.com