



PATIENT REFERRAL

Fax to: 416-506-0600

Email: referrals@triofertility.com

Attn: NEW PATIENT COORDINATOR

Patient Information:

Affix patient label if possible

Name:

Address:

OHIP #:

DOB

Email:

Phone:

Patients must be <39 to be eligible for egg freezing.

Reason for Referral: Egg Freezing

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:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Dr. Kaajal Abrol | <input type="checkbox"/> Dr. Ken Cadesky | <input type="checkbox"/> Dr. Robert Casper | <input type="checkbox"/> Dr. Paul Chang |
| <input type="checkbox"/> Dr. Beth Gunn | <input type="checkbox"/> Dr. Michael Hartman | <input type="checkbox"/> Dr. Carl Laskin | <input type="checkbox"/> Dr. Dan Nayot |
| | <input type="checkbox"/> Dr. Judith Perry | <input type="checkbox"/> Dr. Sony Sierra | |

If you have a preference, please indicate.

Referring Physician Signature: _____

Billing #: _____ Fax: _____

PRINT Name: _____

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

ADVANCING REPRODUCTIVE CARE

T 416 506 0804 TF 1866 543 3046 F 416 506 0600

655 Bay St, 11th and 18th floors Toronto, ON M5G 2K4 Canada

triofertility.com