



PATIENT SELF REFERRAL

Fax to: 416-506-0600

Email: referrals@triofertility.com

Attn: NEW PATIENT COORDINATOR

Your Information:

Name:

Address:

OHIP #:

DOB

Email:

Phone:

Reason for Referral

- Trying unsuccessfully PCOS Endometriosis Donor Egg
 Recurrent loss Genetics Male factor Other_____

Have you been seen by TRIO before? Y N

Have you undergone fertility investigations or treatment before? Y N

If yes, please attach any relevant information or list below. Please 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 needs. You will see one of the following doctors. If you have a preference, please indicate.

- Dr. Ken Cadesky Dr. Robert Casper Dr. Paul Chang
 Dr. Sony Sierra Dr. Dan Nayot Dr. Judith Perry

You will be contacted within 3 business days with an appointment date.

ADVANCING REPRODUCTIVE CARE

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triofertility.com