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:

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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 MD Signature: ________________________ Billing #:__________________________

Phone Number ___________________________ Fax: ____________________________________

Address: __________________________________ PRINT Name: ____________________________

Patients will be contacted by a TRIO team member with an appointment date.

ADVANCING REPRODUCTIVE CARE

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