PATIENT SELF REFERRAL

Fax to: 416-506-0600

Email: referrals@triofertility.com

Attn: NEW PATIENT COORDINATOR

Your Information:

Name:
Address: Email:
OHIP #:
DOB 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:

_____

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

ADVANCING REPRODUCTIVE CARE

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