PATIENT REFERRAL

Attn: New Patient Coordinator I Fax: 416-506-0600 I Email: referrals@triofertility.com

Patient Info: *Affix patient label if possible*

Name: ________________________________

Address: ________________________________ **Email**: ______________________

OHIP #: ________________________________

DOB ________________________________ Phone: ______________________

Reason for Referral (please check)

☐ Donor egg ☐ Endometriosis ☐ Genetics ☐ Recurrent loss

☐ Donor sperm ☐ Fertility testing ☐ Male factor ☐ PCOS

☐ Autoimmune ☐ Other:__________

Has this patient been seen by TRIO before? ☐ Yes ☐ No

Please attach any relevant information such as previous cycles and testing. Prior testing is not required.

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 prefer a doctor, please check.

☐ Dr. Kaajal Abrol ☐ Dr. Robert Casper ☐ Dr. Beth Gunn ☐ Dr. Chaula Mehta

☐ Dr. Ken Cadesky ☐ Dr. Paul Chang ☐ Dr. Hananel Holzer ☐ Dr. Sony Sierra

☐ Dr. Arielle Cantor ☐ Dr. Shirin Dason ☐ Dr. Carl Laskin ☐ Any TRIO Physician

Preferred location (if applicable): _______________________________

Referring Physician Signature: ____

Billing #:____________________________ Fax: _______________________________

PRINT Name: ____