TRIO

PATIENT REFERRAL

Fax to: 416-506-0600 I 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
- ☐ Recurrent loss
- ☐ PCOS
- ☐ Genetics
- ☐ Endometriosis
- ☐ Male factor
- ☐ Donor Egg
- ☐ Other_____

Has this patient been seen by TRIO before? ☐ Y ☐ N

Please attach any relevant information such as previous cycles and testing. 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. If you have a preference, please indicate.

- ☐ Dr. Kaajal Abrol
- ☐ Dr. Beth Gunn
- ☐ Dr. Chaula Mehta
- ☐ Dr. Mohammad Albar
- ☐ Dr. Ken Cadesky
- ☐ Dr. Katharine Phillips
- ☐ Dr. Arielle Cantor
- ☐ Dr. Paul Chang
- ☐ Dr. Robert Casper
- ☐ Dr. Carl Laskin
- ☐ Dr. Sony Sierra
- ☐ Dr. Cassandra Greenberg

Referring Physician Signature: _____

Billing #:_____ Fax: _____

PRINT Name: _____