



**PATIENT REFERRAL**

Attn: New Patient Coordinator | Fax: 416-506-0600 | Email: [referrals@triofertility.com](mailto:referrals@triofertility.com)

Patient Info: *Affix patient label if possible*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

*(Email is required to book appointment)*

OHIP #: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for Referral (please check)

- Donor egg
- Donor sperm
- Autoimmune
- Endometriosis
- Fertility testing
- Other: \_\_\_\_\_
- Genetics
- Male factor
- Recurrent loss
- PCOS

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. Ken Cadesky
- Dr. Arielle Cantor
- Dr. Nickan Motamedi
- Dr. Robert Casper
- Dr. Paul Chang
- Dr. Shirin Dason
- Dr. Sony Sierra
- Dr. Beth Gunn
- Dr. Hananel Holzer
- Dr. Carl Laskin
- Any Physician
- Dr. Chaula Mehta
- Dr. Akanksha Kulshreshtha
- Dr. Katharine Phillips

Preferred location (if applicable): \_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_

Billing #: \_\_\_\_\_ Fax: \_\_\_\_\_

PRINT Name: \_\_\_\_\_