TRIO

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: _____

_____ *(Email is required to book appointment)*

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:

_____

_____

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	☐ Dr. Katharine Phillips
☐ Dr. Nickan Motamedi	☐ Any Physician		

Preferred location (if applicable): _____

Referring Physician Signature: _____

Billing #:_____ Fax: _____

PRINT Name: _____