PATIENT REFERRAL

Fax to: 416-506-0600

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
- ☐ PCOS
- ☐ Endometriosis
- ☐ Donor Egg
- ☐ Recurrent loss
- ☐ Genetics
- ☐ Male factor
- ☐ 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:

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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 have a preference, please indicate.

- ☐ Dr. Kaajal Abrol
- ☐ Dr. Ken Cadesky
- ☐ Dr. Robert Casper
- ☐ Dr. Paul Chang
- ☐ Dr. Beth Gunn
- ☐ Dr. Katharine Phillips
- ☐ Dr. Carl Laskin
- ☐ Dr. Arnold Mahesan
- ☐ Dr. Chaula Mehta
- ☐ Dr. Ruth Ronn
- ☐ Dr. Sony Sierra

Referring Physician Signature: _____

Billing #:_____ Fax: _____

PRINT Name: _____

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655 Bay Street, Suite 1101 & 1800,
Toronto, ON M5G 2K4
T 416 506 0804 | F 416 506 0600

Thornhill
7330 Yonge Street, Suite 217,
Thornhill, ON L4J 7Y7
T 905 731 5928 | F 905 731 4563

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4025 Yonge Street, Suite 215,
North York, ON M2P 2E3
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