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. Ruth Ronn
☐ Dr. Judith Perry ☐ Dr. Sony Sierra

Referring Physician Signature: _____

Billing #:_____ Fax: _____

PRINT Name: _____

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ADVANCING REPRODUCTIVE CARE

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