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:

_____

_____

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 ☐ Dr. Cassandra Greenberg

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

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