

FERTILITY REFERRAL FORM

PATIENT INFORMATION / AFFIX LABEL

PARTNER INFORMATION / AFFIX LABEL

REASON FOR FERTILITY REFERRAL - CHECK ALL THAT APPLY

ASSESSMENT

- ☐ Primary infertility
- ☐ Secondary infertility
- ☐ Recurrent pregnancy loss
- ☐ Irregular cycles / anovulation / PCOS
- ☐ Known / suspected tubal factor
- ☐ Endometriosis

FAMILY-BUILDING

- ☐ Known / suspected male factor
- ☐ Single-parent family building
- ☐ 2SLGBTQ+ family building
- ☐ Donor sperm / donor egg consultation
- ☐ Fertility preservation / egg freezing
- ☐ Urgent medical / oncology preservation

TREATMENT / OTHER

- ☐ IUI consultation
- ☐ IVF consultation
- ☐ Cycle monitoring
- ☐ Preconception counselling
- ☐ Second opinion
- ☐ Other

CLINICAL INFORMATION

Specific referral question / relevant reproductive and medical history

Fertility snapshot (if known)

Duration trying

LMP

Cycle length / regularity

Relevant records attached (Referral will not be delayed if information is unavailable)

- ☐ Hormonal bloodwork
- ☐ Pelvic U/S / AFC
- ☐ Tubal assessment
- ☐ Semen analysis
- ☐ Prior treatment records

REFERRING CLINICIAN

Clinician name

Billing number

Date

Signature

Clinic / address

Phone

Fax

FERTILITY REFERRALS ONLY

This clinic is for patients requesting fertility assessment or treatment.

General gynecology referrals for abnormal bleeding or endometriosis where fertility is not desired should be referred to a general gynecology clinic.

PLEASE INCLUDE Name, date of birth, OHIP number/version, phone and email for the patient and participating partner.
The clinic will contact the patient directly after the referral is received.