REFERRAL FORM

genesis fertility centre

PATIENT INFORMATION

Female Name _____ Date of Birth _____
surname first name yy mm dd

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Personal Health Numbers: Female _____ Partner _____

Partner's Name _____ Date of Birth _____
surname first name yy mm dd

Address (Required)_____
postal code

Referring Doctor _____ Billing Number _____
surname initials

Office Phone No:( ) _____ Office Fax No: ( ) _____

Does this patient speak and understand English? _____ No _____ Yes *If no, please advise patient to bring an interpreter to the appointment.

Referral to Vancouver Office: ☐ Dr. Sonya Kashyap
☐ Clinic to Designate ☐ Urologist

Referral to Surrey Office: ☐ Dr. Sonya Kashyap

REASON FOR REFERRAL (check all that apply)

☐ In Vitro Fertilization (IVF)
☐ Male Factor Infertility
☐ Pre-implantation Genetic Diagnosis
☐ ICSI / Micromanipulation
☐ Donor Insemination
☐ Endometriosis
☐ Ovulation Induction
☐ Superovulation / IUI
☐ Donor Egg
☐ Unexplained infertility
☐ Ovulatory Disorder

SUPPORTING DOCUMENTATION **(Please include copies of the following investigations, if done)**

Female Partner

☐ Hysterosalpingogram
☐ Laparoscopy
☐ Other Gyne surgery reports (if done)
☐ Relevant consult letters
☐ FSH and estradiol levels (on cycle day 2, 3 or 4 only)
☐ Luteal phase progesterone (if done)
☐ Rubella titre and blood group
☐ Previous IVF cycle records (ovulation induction flow sheet, egg data and embryo data)

Male Partner

☐ Semen analysis (most recent & any abnormal tests)
☐ Urological consult (if done)
☐ Sperm antibodies/specialized semen tests (if done)

Comments: _____

_____

_____

Suite 300 – 1367 West Broadway, Vancouver, BC V6H 4A7 Tel: 604-879-3032 Fax: 604-875-1432
www.genesis-fertility.com