Website Referral Form

PATIENT INFORMATION

Patient Name: ____________________ (Surname) ______________________________ (First Name) **Gender:** ☐ F ☐ M ☐ O

Date of Birth: ________________________________ (YY / MM / DD) **Email:** ______________________________

Patient PHN: ______________________________

Phone: (   ) ______________________________ **Cell Phone: (   )** ______________________________

Email: ______________________________

Partner's Name: ____________________ (Surname) ____________________ (First Name) **Gender:** ☐ F ☐ M ☐ O

Partner PHN: ______________________________ **Partner Email:** ______________________________

Phone: (   ) ____________________ **Cell Phone: (   )** ____________________ **DOB:** ___/___/___ (YY MM DD)

Address (Required) ____ (Postal Code)

Referring Doctor: ______________________________ **Billing Number:** ______________________________

Phone: (   ) ______________________________ **Cell Phone: (   )** ______________________________

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

Has the patient consented to email communications? _____**Yes** _____**No**

REFERRAL TO VANCOUVER OFFICE

- ☐ Dr. Sonya Kashyap
- ☐ Dr. Neeraj Mehra (Surgery)
- ☐ Dr. Victor Chow
- ☐ Dr. Flannigan
- ☐ Clinic to Designate

REASON FOR REFERRAL (Check all that apply)

- ☐ In Virto Fertilization (IVF)
- ☐ Pre-implantation Genetic Screening/Diagnosis
- ☐ Tubal Reversal/Reproductive Surgery
- ☐ Donor Insemination
- ☐ Recurrent Pregnancy Loss
- ☐ IUI ☐ Egg Freezing ☐ Donor Egg

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

Female Partner

- ☐ Hysterosalpingogram
- ☐ Luteal Phase Progesterone (if done)
  FSH and Estradiol Levels (on cycle day 2, 3, or 4 only)
- ☐ Relevant Consult Letters
- ☐ AMH ☐ Rubella Titre and Blood Group
- ☐ Other Gyne Surgery Reports (if done)
- ☐ 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)

Duration of Infertility: <1 year 1-3 Years 5 years **PREVIOUS INFERTILITY TREATMENT:** Yes No

Comments: ____

Suite 300 – 1367 West Broadway, Vancouver, BC V6H 4A7 | genesis-fertility.com | **TEL:** 604.879.3032
PLEASE RETURN VIA FAX OF EMAIL | **FAX:** 604.875.1432 | **EMAIL:** admin@genesis-fertility.com