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Referral Form

On-site Laboratory On-site Ultrasound

Patient Name: _____ Health Card Number: _____

Address: _____ Phone Number: _____

DOB: / /

***Reason for referral**: (Please attach patient documentation or investigations):*

_____

_____

_____

Referring Doctor Name & Signature:

_____ _____ OHIP Billing # _____

Infertility Treatment	**General Gynecology**
☐ Infertility investigations and Cycle Monitoring	☐ PAP Smear
☐ Advanced Semen Analysis	☐ IUD Insertion
☐ Sonohysterogram +/- Tubal Patency Testing	☐ Birth Control
☐ Intrauterine Insemination	☐ Abnormal Uterine Bleeding/ Post-Menopausal Bleeding
☐ IVF	☐ Endometrial Ablation
☐ Donor Insemination, Egg Donation & Gestational Carrier	☐ Endometriosis
☐ Recurrent Pregnancy Loss	☐ Endometrial Biopsy
☐ Tubal Re-anastomosis Surgery	☐ Pelvic & Transvaginal Ultrasound
☐ Fertility Preservation (Sperm, Oocytes, Embryos)	☐ Uterine Fibroids, Polyps, Septum
	☐ Management of Ovarian Cysts
Early Pregnancy Care Unit	**Reproductive Endocrinology**
☐ Pregnancy Test (same day results)	☐ Management of Menopause
☐ Pregnancy Ultrasound (Dating & viability)	☐ Management of Menstrual Disorders
☐ Early Pregnancy Bleeding Evaluation	☐ PCOS (Investigations & Management)
☐ Nuchal Translucency, IPS Testing	☐ Premature Ovarian Insufficiency
☐ Pregnancy Evaluation & Monitoring	☐ HRT

Andrology & Men's Health

☐ Low libido ☐ Erectile dysfunction

☐ Ejaculatory dysfunction ☐ Abnormal sperm analyses