

**ISIS REGIONAL FERTILITY CENTRE**

2180 Meadowvale Blvd.  
Mississauga, Ontario  
L5N 5S3

Phone: 905-816-9822

Fax: 905-816-9833

## REFERRAL FORM

Date of Referral: \_\_\_\_\_

**Referring Physician (to be completed by physician office)**

Name: \_\_\_\_\_ Physician Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Partner Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Contact number: 1.** \_\_\_\_\_ **2.** \_\_\_\_\_

**Referral to:**

<input type="checkbox"/> Dr. M. Gysler	<input type="checkbox"/> Dr. C. Lee	<input type="checkbox"/> Dr. H. Cheng
<input type="checkbox"/> Dr. G. Goodrow	<input type="checkbox"/> Dr. M. Fischer	<input type="checkbox"/> Dr. K. Elford
<input type="checkbox"/> Dr. E. Ewaschuk	<input type="checkbox"/> Dr. P. Scheufler	<input type="checkbox"/> Dr. P. Vaidyanathan
<input type="checkbox"/> Any Physician	<input type="checkbox"/> Dr. M. Abou-Seido	<input type="checkbox"/> Dr. W. Jong

**Reason for Referral:**

<input type="checkbox"/> Female Infertility	<input type="checkbox"/> Male Infertility
<input type="checkbox"/> Recurrent Pregnancy Loss	<input type="checkbox"/> Surgery
<input type="checkbox"/> In Vitro Fertilization	<input type="checkbox"/> Reproductive Endocrinology
<input type="checkbox"/> Donor Insemination	<input type="checkbox"/> Cancer Patients – Fertility Preservation
<input type="checkbox"/> Infertility Counseling	<input type="checkbox"/> Other

Please see Page Two for recommended tests that may accompany patient.

**Patients will be phoned immediately to arrange a consultation within 2-4 weeks of receipt of Consultation Request.**

**Information/tests performed in the past 3 months for female and male patients (please include with referral):**

Female	Male
<input type="checkbox"/> Day 3 FSH	<input type="checkbox"/> HIV 1 & 2
<input type="checkbox"/> TSH, Prolactin	<input type="checkbox"/> Hepatitis B, C
<input type="checkbox"/> HIV 1 & 2	<input type="checkbox"/> Blood Type
<input type="checkbox"/> Hepatitis B, C	<input type="checkbox"/> Semen Analysis
<input type="checkbox"/> Rubella	<input type="checkbox"/> VDRL
<input type="checkbox"/> Hysterosalpingogram	<input type="checkbox"/> Other
<input type="checkbox"/> Pelvic Ultrasound	
<input type="checkbox"/> Surgery Reports	
<input type="checkbox"/> CBC	
<input type="checkbox"/> VDRL	
<input type="checkbox"/> Other	