

Referral Form

Date: _____

Patient Name: _____

Address: _____

MB Health #: _____ PHIN (9 digit #): _____ Date of Birth D/M/Y: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Partner Name: _____

Address: _____

MB Health #: _____ PHIN (9 digit #): _____ Date of Birth D/M/Y: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Referring Physician (To be completed by Referring Physician's office)

Referring Physician: _____ **Physician number:** _____

Phone number: _____ **Fax:** _____

Address: _____

Referral to: (check patient preference)

- Dr. Jeremy Kredenster Dr. Francis Lee Dr. Gordon McTavish First Available Physician

Reason for Referral: (check applicable)

Infertility

- | | | |
|---|--|--|
| <input type="radio"/> IVF or ICSI | <input type="radio"/> General Infertility | <input type="radio"/> Donor Sperm Insemination |
| <input type="radio"/> Recurrent Pregnancy Loss | <input type="radio"/> Donor Egg | <input type="radio"/> Gestational Surrogacy |
| <input type="radio"/> Cancer Fertility Preservation | <input type="radio"/> Reproductive Endocrinology | <input type="radio"/> Other: _____ |
| | <input type="radio"/> Sperm Freezing | |

Gynecology

- | | | |
|---|--|--|
| <input type="radio"/> Abnormal Uterine Bleeding | <input type="radio"/> Incontinence | <input type="radio"/> Minimally Invasive Surgery |
| <input type="radio"/> Women's Health | <input type="radio"/> Tubal Reversal Surgery | <input type="radio"/> Other: _____ |

Investigations:

Please include all relative consultations and investigations. If you are referring a patient, for fertility treatment, please include the following information from tests performed in the last 3 months for female and male patients & include with your referral form/request.

Female Fertility Patients

- | | | |
|---|--------------------------------------|---|
| <input type="radio"/> Day 3 FSH | <input type="radio"/> TSH, Prolactin | <input type="radio"/> HIV 1 & 2 |
| <input type="radio"/> Hepatitis B, C | <input type="radio"/> Rubella | <input type="radio"/> Hysterosalpingogram |
| <input type="radio"/> Pelvic Ultrasound | <input type="radio"/> Varicella | <input type="radio"/> Surgery Reports |
| <input type="radio"/> CBC | <input type="radio"/> VDRL | <input type="radio"/> Other: _____ |

Male Fertility Patients

- | | | |
|--------------------------------------|--------------------------------------|------------------------------------|
| <input type="radio"/> HIV 1 & 2 | <input type="radio"/> Hepatitis B, C | <input type="radio"/> Blood Type |
| <input type="radio"/> Semen Analysis | <input type="radio"/> VDRL | <input type="radio"/> Other: _____ |

Comments: _____

Heartland will contact your patient, to arrange a consultation once a referral has been received.

Thank you for referring your patients to Heartland!