GRACE FERTILITY

Patient Referral Form

PATIENT LABEL (INTENDED CARRIER) / PARTNER LABEL [IF APPLICABLE SPERM / EGG PROVIDER]

Today's Date DD MM YYYY

☐ **URGENT: Oncology or other medically necessary fertility preservation**
Please attach all notes / reports.
Patient will be contacted within 24 hours.

Referring Physician

Name

MSP #

Fax

Phone

Email

Street Address

City

Province

Patient Information

Name

Preferred Name

PHN

Date of Birth DD MM YYYY

Phone

E-mail

Biological / Assigned Sex
- ☐ Female
- ☐ Male
- ☐ Other _____

Preferred Pronouns
- ☐ She / Her
- ☐ He / Him
- ☐ They / Them
- ☐ Other _____

☐ **BMI >40**

Partner Information

Name

Preferred Name

PHN

Date of Birth DD MM YYYY

Phone

E-mail

Biological / Assigned Sex
- ☐ Female
- ☐ Male
- ☐ Other _____

Preferred Pronouns
- ☐ She / Her
- ☐ He / Him
- ☐ They / Them
- ☐ Other _____

Reason(s) for Referral

Infertility and Assisted Reproduction
- ☐ Infertility Investigation and Management
- ☐ Ovulation Induction
- ☐ In Vitro Fertilization (IVF)
- ☐ Intrauterine Insemination (IUI)
- ☐ Donor Sperm Insemination
- ☐ Egg Cryopreservation
- ☐ Sperm Cryopreservation

Andrology
- ☐ Sperm Functional Assessment
- ☐ Pre-ICSI Assessment
- ☐ Sperm Cryobanking

Reproductive Endocrinology
- ☐ Polycystic Ovary Syndrome
- ☐ Amenorrhea and Irregular Periods
- ☐ Hyperpolactinemia
- ☐ Menopause

Pertinent Medical History and Previous Tests

Once we receive your referral by fax (604-558-4246), we will contact your patient to arrange a consultation. Thank you for entrusting us with your patient's care.

#210-604 West Broadway, Vancouver, BC V5Z 1G1 | **T: 604-558-4886 | F: 604-558-4246**