REFERRAL FORM

NEO WOMEN'S HEALTH NETWORK

Fax Completed Form to (705)-222-7226

NORTHEASTERN FERTILITY SERVICES

of pages: _____

PATIENT INFORMATION *(Please print clearly)*

Patient Name: _____
Last Name First Name

Date of Birth: _____ Health Card # _____
dd/mm/yy

Patient Address: _____

Patient Email: _____ Patient Phone #: _____

PARTNER INFORMATION *(Please print clearly)*

Partner Name: _____
Last Name First Name

Date of Birth: _____ Health Card # _____
dd/mm/yy

Partner Address: _____

Partner Email: _____ Partner Phone #: _____

Referring Physician Name: _____

Physician Billing Number: _____

Office Phone #: _____ Office Fax #: _____

Patient – Indicate Areas of Concern:
Infertility and Assisted Reproduction

- ☐ Infertility Investigation and Management
- ☐ Ovulation Induction
- ☐ Intrauterine Insemination (IUI)
- ☐ In Vitro Fertilization (IVF)
- ☐ Donor Sperm Insemination
- ☐ Male Factor Infertility
- ☐ Cycle Monitoring
- ☐ Other: _____

Supporting documentation, if available:
Recent Investigations (<6 months)

- ☐ Laparoscopy or other gyne. surgery reports
- ☐ Relevant consult letters
- ☐ Previous IVF cycle records
- ☐ Semen analysis (most recent & any abnormal tests)
- ☐ Relevant consult letters
- ☐ Urological consult (if done)
- ☐ Other: _____

Comment:

Physician/NP signature:_____