SELF-REFERRAL FORM

Date:_____

PATIENT'S NAME:	
Address:	
Health Card No.:	**VC:**
DOB:	
Phone:	**Fax:**
REFERRAL TO: ☐	

REASON:

- ☐ Endometriosis
- ☐ Polycystic Ovarian Syndrome
- ☐ Primary Ovarian Insufficiency
- ☐ Hyperprolactinemia
- ☐ Drug Treatment for Ovulation Boost
- ☐ Intrauterine Insemination
- ☐ In Vitro Fertilization
- ☐ Intracytoplasmic Sperm Injection W/O Embryo Transfer
- ☐ Pregnancy loss
- ☐ Uterine tumor
- ☐ Other, please specify:_____

Please enclose any relevant blood work, histology, chemotherapy, radiology, imaging, surgical reports or consultations.

Patients will be contacted directly within one week of receiving referrals to arrange an appointment. If the patient has not heard from us within this time, please contact us at 1-888-844-9838 to ensure the referral was received.