

PATIENT REFERRAL

PLEASE FAX THIS FORM TO: 416-972-0036



To: Dr. R. Casper Dr. Y. Bentov Dr. P. Chang Dr. M. Mitwally

First Available

From (Referring Physician):

Name:	
Address:	
Fax:	Phone:
OHIP Billing Number:	

Patient Information:

Name:	
Date of Birth:	
Address:	
Health Card #:	Phone:
Reason For Referral & Patient Health Information:	

Please include the following if available:

Female:

1. Blood test: Blood group & Rh status, Rubella, HIV I & II, HBsAg, Hep C & VDRL
2. Cycle day 3 blood tests: FSH, LH, Estradiol, Prolactin & TSH
3. Pap smear result within the previous 24 months
4. Previous fertility tests and treatments
5. Results of pelvic ultrasound (past 6 months) Reports of Hysteroscopy / Laparoscopy / Hysterosonogram
6. Hemoglobin Electrophoresis, Tay Sachs Screening

Male:

1. Blood Tests: Blood Group & Rh status, HIV I & II, HTLV I & II, HBsAg, Hep C and VDRL.
2. Semen Analysis results within the previous 12 months
3. Hemoglobin Electrophoresis, Tay Sachs Screening

• **Patients will be contacted within 1-2 weeks**

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