Dr. Chaula Mehta's
TRIO FERTILITY
MISSISSAUGA

PATIENT REFERRAL FORM

Date: (DD/MM/YYYY): _____ /_____/_____

☐ URGENT
For Medically Required Fertility Preservation
We will contact your patient within 48 hours

Please attach any relevant information such as previous cycles and testing. Patient will be asked to bring all relevant and current test results to their initial consultation.

PATIENT DEMOGRAPHICS (as per health card)	PARTNER DEMOGRAPHICS (if applicable and as per health card)
Name: _____	Name: _____
DOB: _____	DOB: _____
HC #: _____	HC #: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Email: (preferrable) _____	Email: (preferrable) _____

REASON FOR REFERRAL

☐ Trying Unsuccessfully	☐ PCOS	☐ Male Factor	☐ Donor Egg
☐ Egg Freezing	☐ IVF	☐ 2SLGBTQIA + Family Building	☐ Surrogacy
☐ Recurrent Pregnancy Loss	☐ Genetics	☐ Onco Fertility Preservation	☐ Other _____

ADDITIONAL INFORMATION:

_____

_____

_____

Referring Physician: _____ **Billing #:** _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

Thank you for your referral !
TRIO Fertility Mississauga will contact your patient with the appointment date and time including any instructions for the appointment.
FAX to 905-581-4471 or Email to referrals@triomississauga.com ATTN: NEW PATIENT REFERRAL

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Phone: 905-581-5505 Fax: 905-581-4471 www.triomississauga.com