

# Patient Referral Form

Ovassure  
 790 Bay St., Suite 1002  
 Toronto, Ontario M5G 1N8  
 Fax: 416-987-5595  
 Web: www.ovassureeggfreezing.com

Date: \_\_\_\_\_

*Affix patient label here or provide details below*

1

Patient Demographics	
Name	
DOB	
Address	
OHIP #	
Tel #	
Email	
Previous Ovassure patient? YES <input type="checkbox"/> NO <input type="checkbox"/>	

Referring Physician/Nurse Practitioner	
Name	
Billing #	
Address	
Tel #	
Fax	
Email	

Physician Preference			
<input type="checkbox"/>	First available Ovassure physician		
<input type="checkbox"/>	Dr. C. Librach	<input type="checkbox"/>	Dr. P. Sharma
<input type="checkbox"/>	Dr. A. Baratz	<input type="checkbox"/>	Dr. Justin Tan
<input type="checkbox"/>	Dr. K. Glass		

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Choose the service			
<input type="checkbox"/>	Fertility Assessment	<input type="checkbox"/>	Social Egg Freezing
<input type="checkbox"/>	AMH Test	<input type="checkbox"/>	
<input type="checkbox"/>	Other:		

**Medical Fertility History:** (Please attach any relevant investigation reports. e.g.: bloodwork, pelvic ultrasound, sonos, etc.)

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**Please Fax to: 416-987-5595**

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**Ovassure will contact your patient with appointment date and time.**