Referral Form

Referrals will be triaged to the next available appointment and each referral form is valid for one year.

Fax completed forms to 403 910 4570.....................................Date of referral (yyyy/mm/dd)__________________

This referral is.. ☐ Urgent.. ☐ Routine

Referring doctor

Referring Doctor..Prac ID...
Clinic name..
Clinic Address...
Clinic phone number..Clinic fax number...

Patient

Patient name...
Date of Birth (yyyy/mm/dd)...PHN...
Patient email address..
Patient mobile number...
Patient Address with postal code...

Partner

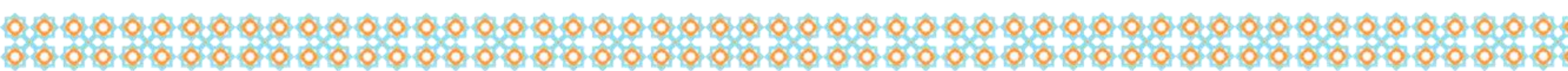
Partner name...
Date of Birth (yyyy/mm/dd) ....PHN...
Partner email address..
Partner mobile number...
Partner Address with postal code...

Does this patient speak and understand English............................... ☐ Yes.. ☐ No
If no, please advise patient to arrange an interpreter for their consultations with Oasis Fertility Centre.

Reason for referral

Previous fertility treatment... ☐ Yes.. ☐ No
Duration of unprotected intercourse (if relevant) ....
☐ Unexplained infertility.......... ☐ Recurrent pregnancy loss............ ☐ Egg freezing............. ☐ Sperm freezing
☐ Male factor infertility............ ☐ Endometriosis............................ ☐ PCOS......................... ☐ Genetic disorders
☐ Require third party reproduction assistance (Use of Donor gametes / gestational carrier)
☐ Others: (Please explain):...
....
....
Supporting documentation: Please include all recent fertility investigations, and previous treatment chart notes, if applicable.

Physician's signature...



410, 23 Sunpark Drive SE, Calgary, AB T2X3V1 | Tel: 403 910 7888 | Fax: 403 910 4570 | referrals@oasisfertility.com | www.oasisfertility.com