Dr. T.Williams
Fertility Centre

PATIENT REFERRAL FORM

PLEASE GIVE THIS FORM TO YOUR DOCTOR TO FILL OUT

Refer To:
Dr. Tanya Williams Fertility Centre
4025 Yonge Street, Suite 215
North York, Ontario M2P 2E3 Canada

Tel. (416) 283 - 5539 Fax. (416) 283-1636
Email: receptionist@drtanyawilliams.com

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Patient Name _____

Date of Birth _____ Years of Infertility _____ Healthcard No. _____

Patient Address _____

Home Phone _____ Mobile Phone _____

Email Address _____

Referring Physician's Name _____ Billing No. _____

Office Address _____

Office Phone _____ Office Fax _____

AREA(S) OF PATIENT CONCERN:

- ☐ Infertility Investigation and Management
- ☐ Ovulation Induction
- ☐ In Vitro Fertilization (IVF)
- ☐ Intrauterine Insemination (IUI)
- ☐ Donor Sperm Insemination (TDI)
- ☐ Donor Egg / Gestational Surrogacy
- ☐ Egg Cryopreservation
- ☐ Male Factor Infertility
- ☐ Preimplantation Genetic Testing
- ☐ Other: _____

SUPPORTING DOCUMENTATION BELOW IS ATTACHED:

- ☐ Relevant consult letters
- ☐ Relevant lab reports
- ☐ Pelvic ultrasound reports
- ☐ Semen analysis (most recent & any abnormal tests)
- ☐ Sonohysterogram / Hysterosalpingogram
- ☐ Laparoscopy or other gyne. surgery reports
- ☐ Previous IVF cycle records
- ☐ Urological consult (if done)

Comment

_____

_____

_____

_____