# *Referral Form*

blossom
FERTILITY + MEDICAL CLINIC

**Patient Name** _____ Date of Birth _____

**Partner Name (*if applicable*)** _____ Date of Birth _____

Home Phone (  ) _____ Work Phone (  ) _____ Cell Phone (  ) _____

Personal Health Number _____

Address _____

Email address _____

**Referring Physician's Name** _____ MSP Number _____

Office email address _____

Can we contact you by email? ☐ YES ☐ NO

**Reason for referral**

☐ Infertility ☐ Donor Egg ☐ Egg Freezing

☐ Donor Sperm ☐ Sperm Freezing ☐ Surrogacy

☐ Recurrent Miscarriage ☐ Transgender care ☐ Tubal Ligation Reversal

☐ URGENT Fertility Preservation/Cancer ☐ Pre-implantation Genetic Diagnosis

**Relevant Records Required**

Imaging Prior Consults Partner Semen Analysis Partner Consults

**Relevant Records Required**

CBC TSH PRL Day 3 FSH Day 21 Progesterone Day 3 Estradiol

Fasting Insulin Serum Testosterone Glucose Fasting

***Please include all relevant investigations and records with your referral.***


Blossom Fertility + Medical Clinic

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