

**Fax Completed Form to  
416-640-9454**

- Attention:**
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Dr. Marjorie Dixon     | <input type="checkbox"/> Dr. Ashley Gilman | <input type="checkbox"/> Dr. Chaula Mehta      |
| <input type="checkbox"/> Dr. Prema Vaidyanathan | <input type="checkbox"/> Dr. Yaakov Bentov | <input type="checkbox"/> Dr. Alyse Goldberg    |
| <input type="checkbox"/> Dr. Jamie Kroft        | <input type="checkbox"/> Dr. Zahra Sharif  | <input type="checkbox"/> Dr. Frederick Dzineku |
| <input type="checkbox"/> Dr. Chloé Roumain      | <input type="checkbox"/> Dr. Khulood Murad | <input type="checkbox"/> Dr. Meredith Giffin   |

**PATIENT INFORMATION** *(Please print clearly)*

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Patient Name: \_\_\_\_\_  
Last Name First Name

Date of Birth: \_\_\_\_\_ Health Card # \_\_\_\_\_  
dd/mm/yy

Patient Address: \_\_\_\_\_

Patient Email: \_\_\_\_\_ Patient Phone #: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_

**Patient – Indicate Areas of Concern:**

*Infertility and Assisted Reproduction*

- Infertility Investigation and Management
- Ovulation Induction
- In Vitro Fertilization (IVF)
- Intrauterine Insemination (IUI)
- Donor Sperm Insemination
- Donor Egg/ Gestational Surrogacy
- Egg Cryopreservation
- Preimplantation Genetic Screening/Diagnosis (PGS/PGD)
- Endometriosis
- Male Factor Infertility
- Other: \_\_\_\_\_

**Supporting documentation, if available:**

- Sonohysterogram/ Hysterosalpingogram
- Laparoscopy or other gyne. surgery reports
- FSH & Estradiol levels (Day 2, 3 or 4 only)
- Endocrine screen (TSH, prolactin)
- Relevant consult letters
- Luteal phase progesterone (if used)
- Previous IVF cycle records
- Semen analysis (most recent & any abnormal tests)
- Urological consult (if done)
- Sperm antibodies/specialized semen tests (if done)

**Comment:**