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701-1661 Portage Ave.
Winnipeg, MB R3J 3T7

HEARTLAND
Fertility & Gynecology Clinic

Referral Form

(Must include both partners' demographics)

Date: _____

Patient Name (as it is on MB Health Card): _____ Goes By (if different): _____

Address (as it is on MB Health Card): _____

MB Health #: _____ PHIN (9 digit #): _____ _____ _____ Date of Birth D/M/Y: _____

Daytime Phone: _____ Email: _____

Gender: M ____ F ____ MTF ____ FTM ____ Non-Binary_____ Other_____ Preferred pronoun_____

Partner Name (as it is on MB Health Card): _____ Goes By (if different): _____

Address (as it is on MB Health Card): _____

MB Health #: _____ PHIN (9 digit #): _____ _____ _____ Date of Birth D/M/Y: _____

Daytime Phone: _____ Email: _____

Gender: M ____ F ____ MTF ____ FTM ____ Non-Binary_____ Other_____ Preferred pronoun_____

Referring Physician *(To be completed by Referring Physician's office)*

Referring Physician: _____ **Physician number:** _____

Phone number: _____ Fax: _____

Address: _____

Reason for Referral: (check applicable)

Infertility

- ☐ IVF or ICSI
- ☐ Recurrent Pregnancy Loss
- ☐ Medically Indicated Fertility Preservation
- ☐ General Infertility
- ☐ Donor Egg
- ☐ Reproductive Endocrinology
- ☐ Sperm Freezing
- ☐ Donor Sperm Insemination
- ☐ Gestational Surrogacy
- ☐ Other: _____

Gynecology

- ☐ Abnormal Uterine Bleeding
- ☐ Tubal Reversal Surgery
- ☐ Minimally Invasive Surgery
- ☐ Other: _____

Comments: _____

_____

_____

Heartland will contact your patient, to arrange a consultation once a referral has been received.
Thank you for referring your patients to Heartland!