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Referral Form

(Must include both partners' demographics)

Date: _____

Patient Name: _____

Address: _____

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

Daytime Phone: _____ Email: _____

Gender: M ___ F ___ MTF ___ FTM ___ Other _____

Partner Name: _____

Address: _____

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

Daytime Phone: _____ Email: _____

Gender: M ___ F ___ MTF ___ FTM ___ Other _____

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

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

Phone number: _____ Fax: _____

Address: _____

Reason for Referral: (check applicable)

Infertility

- | | | |
|---|---|---|
| <input type="checkbox"/> IVF or ICSI | <input type="checkbox"/> General Infertility | <input type="checkbox"/> Donor Sperm Insemination |
| <input type="checkbox"/> Recurrent Pregnancy Loss | <input type="checkbox"/> Donor Egg | <input type="checkbox"/> Gestational Surrogacy |
| <input type="checkbox"/> Medically Indicated Fertility Preservation | <input type="checkbox"/> Reproductive Endocrinology | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sperm Freezing | | |

Gynecology

- | | |
|--|---|
| <input type="checkbox"/> Abnormal Uterine Bleeding | <input type="checkbox"/> Minimally Invasive Surgery |
| <input type="checkbox"/> Tubal Reversal Surgery | <input type="checkbox"/> Other: _____ |

Investigations:

Please include all relative consultations and investigations. If you are referring a patient, for fertility treatment, please include the following information from tests performed in the last 3 months for female and male patients & include with your referral form/request.

Female Fertility Patients

- | | | | |
|---|------------------------------------|--|---|
| <input type="checkbox"/> Cycle Day 2-4 FSH, E2 & LH | <input type="checkbox"/> HbsAb | <input type="checkbox"/> Rubella | <input type="checkbox"/> Pap History |
| <input type="checkbox"/> Cycle Day 21-24 Progesterone | <input type="checkbox"/> HbsAg | <input type="checkbox"/> Varicella | <input type="checkbox"/> Ultrasound Reports |
| <input type="checkbox"/> AMH | <input type="checkbox"/> HCV | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Surgery Reports |
| <input type="checkbox"/> TSH | <input type="checkbox"/> HIV 1 & 2 | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> HSG Reports |
| <input type="checkbox"/> Prolactin | <input type="checkbox"/> VDRL | <input type="checkbox"/> Blood Type & Rh | <input type="checkbox"/> Other: _____ |

Male Fertility Patients

- | | | | | |
|--|------------------------------------|------------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Semen Analysis | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> HIV 1 & 2 | <input type="checkbox"/> HbsAg | <input type="checkbox"/> VDRL |
| <input type="checkbox"/> Blood Type & Rh | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> HCV | <input type="checkbox"/> HbsAB | <input type="checkbox"/> 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!