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Winnipeg, MB R3J 3T7

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

- | | | |
|---|---|---|
| <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: _____ |

Comments: _____

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