OLIVE
fertility centre
KELOWNA

Referral Form / KELOWNA 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 ______________

Referring physician phone number ______________________

Referring physician fax number ______________________

Kelowna Office ☐ Clinic to Designate ☐ Dr. Katherine Wise ☐ Dr. Kim Daniel ☐ Dr. Glenn Benoit

Reason for referral

- ☐ Infertility
- ☐ Donor Egg
- ☐ Egg Freezing
- ☐ Donor Sperm
- ☐ Sperm Freezing
- ☐ Surrogacy
- ☐ Pre-implantation Genetic Diagnosis
- ☐ Recurrent Miscarriage
- ☐ Transgender care
- ☐ URGENT Fertility Preservation/Cancer
- ☐ OB / GYN

Relevant History:

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Please include all relevant investigations and records with your referral and fax this form to our office at the fax number provided below.

202-1630 Pandosy St., Kelowna, BC, V1Y 1P7

tel: 250-861-6811 *fax:* 250-861-6814

To download more printable referral forms or to submit a referral online:
olivefertility.com/referring-physicians