Referral Form / VICTORIA CLINIC

OLIVE
fertility centre
VICTORIA

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 _____

Office email address _____ Can we contact you by email? YES / NO

Victoria Office ☐ Dr. Ginevra Mills ☐ Dr. James Graham ☐ Clinic to Designate

Reason for referral

☐ Infertility ☐ Donor Egg ☐ Egg Freezing

☐ Donor Sperm ☐ Recurrent Miscarriage ☐ Surrogacy

☐ Transgender care ☐ Pre-implantation Genetic Diagnosis

☐ URGENT Fertility Preservation/Cancer

Relevant History:

_____

_____

_____

_____

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

545 Superior Street, Suite 210, Victoria, BC V8V 0C5

tel: 250-410-1664 *fax:* 604-559-9951

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