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. 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