OLIVE *fertility centre*

Referral Form | ONCOLOGY

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Partner Name *(if applicable)* _____ Date of Birth _____

Home / Cell Phone _____ Work Phone _____

Personal Health Number _____

Address _____

Email Address _____

REFERRER INFORMATION

Referring Physician's Name _____ MSP Number _____

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

DIAGNOSIS & TREATMENT

Diagnosis _____

_____

Staging *(if available)* _____

Planned Treatment:

o Chemotherapy - regimen: _____

o Radiation - site: _____

o Other: _____

ASA Status _____ **Anesthetic consult done** *(if yes, attach)*: YES / NO

Fertility preservation is a 2-3 week process: *does this delay in starting treatment or IVF itself affect the prognosis?* YES / NO

ADDITIONAL INFORMATION

- If your patient being referred to Olive Fertility for consideration of egg or embryo freezing, please help arrange the following investigations **at Lifelabs** (hospital turnaround time is too long & may delay start) to help expedite the process:
  - ID screens *(include details)*
  - AMH
  - CBC, hemoglobin electrophoresis, TSH

- Please fax this form and **ALL RELEVANT CONSULTS, IMAGING, PATHOLOGY, AND SURGERY REPORTS**, additional oncology referral forms can be downloaded at olivefertility.com/referring-physicians

Vancouver
555 West 12th Ave.
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F:250-861-6814

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F: 604-559-9951

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