

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:

- Chemotherapy - regimen: _____
- Radiation - site: _____
- 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.
T: 604.559.9950
F: 604.559.9951

Victoria

545 Superior St.
T: 250.410.1664
F: 250.999.8838

Kelowna

1630 Pandosy St.
T: 250.861.6811
F: 250.861.6814

Surrey

13737 96 Ave.
T: 604.559.9950
F: 604.559.9951

Prince George

299 Victoria St.
T: 250.612.0867
F: 250.564.0199