Mount Sinai Fertility
Sinai Health System

250 Dundas St W., Suite 700
Toronto, ON M5T 2Z5
Tel: 416-586-4748

# PATIENT REFERRAL

## Fax: 416-586-4686

Patients will be contacted within 1 week from receipt of this referral.

**Date: (dd/mm/yyyy) _____**

**Referral to:**

- ☐ Rebecca Arthur, BSc (Hon), MSc, MD, FRCSC
- ☐ Ellen Greenblatt, MDCM, FRCSC, FACOG (REI)
- ☐ Kimberly Liu, MD, FRCSC, MSL
- ☐ Heather Shapiro, MD, FRCSC
- ☐ Crystal Chan, MD, MSc, FRCSC (North York location- 2 Sheppard Ave E, Suite 430)
- ☐ Claire Jones, BSc, MD, FRCSC (Vaughan location- 9600 Bathurst St, Suite 300)
- ☐ FIRST AVAILABLE

*The MSF team also includes reproductive endocrinology and infertility fellows and a nurse practitioner.*

**PATIENT DEMOGRAPHICS:**
Previous patient of Mount Sinai Fertility? ☐ Y/☐ N

Name: _____
DOB: _____
HC #: _____
Address: _____
Phone: _____
Email: _____

**PARTNER DEMOGRAPHICS:**
(Please provide, if applicable, to facilitate appt booking)

Name: _____
DOB: _____
HC #: _____
Address: _____
Phone: _____
Email: _____

**REFERRING PRACTITIONER: _____ Billing #: _____**

Phone: _____ Fax: _____

Email: _____

☐ **Infertility**

☐ **Recurrent Pregnancy Loss**

☐ **Preimplantation Genetic Diagnosis**

☐ **Donor Sperm / Donor Egg / Gestational Carrier**

☐ **Egg Freezing**

☐ **Sperm Banking**

☐ **Clinical Details:** _____

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*Please include, if available, any relevant investigations and results for the patient and, if applicable, the partner: previous fertility testing & treatments, recent blood tests, ultrasounds, semen analysis results, genetic testing, and abdominal or pelvic surgery reports.*

☐ **Fertility Preservation – Oncology/Medical Need** please attach consult notes, pathology & surgery reports. Specific details of the planned treatment (ie. Chemo drugs) and timelines will help expedite urgent care.

Diagnosis: _____

☐ **Chemotherapy** ☐ **Radiation Therapy** ☐ **Surgery** ☐ **Treatment completed**

**Details: _____ Start date: _____**

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