Mount Sinai Fertility
Sinai Health System

800 Southdown Rd, Unit A4 Tel: 905-901-5123
Mississauga, ON L5J 2Y4

PATIENT REFERRAL

FAX: 905-823-2013

Confirmation of receipt of completed referral will be sent to referring doctor's office.

Referral to:
Shannon Moore, MSc, MD, FRCSC
800 Southdown Rd, Mississauga, ON

Date: (dd/mm/yyyy)_____

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

REFERRING PRACTITIONER:_____Billing #: _____

Phone:_____Fax: _____

Email: _____

PATIENT DEMOGRAPHICS (as per health card):
(Mandatory requirements for appointment booking)
Previous patient of Mount Sinai Fertility? ☐ Y/☐ N

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

PARTNER DEMOGRAPHICS (as per health card):
(Mandatory requirements for appointment booking)
☐ **N/A**

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

☐ **Infertility** ☐ **Recurrent Pregnancy Loss** ☐ **Sperm Banking**
☐ **Preimplantation Genetic Diagnosis** ☐ **Donor Sperm / Donor Egg / Gestational Carrier**

☐**Clinical Details:** _____

Please include, if available, any relevant investigations and results for the patient and, if applicable, the partner: previous fertility testing & treatments, bloodwork results from <1 year, 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. **Please note: Egg retrieval cannot be performed safely in patients with a BMI >40 or beyond ASA class I-II. Sedation is provided in an outpatient setting without anesthetists present.**

Diagnosis: _____

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

Details: _____**Start date:** _____