



Date: (DD/MM/YYYY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# PATIENT REFERRAL

Fax: 416-586-4686

**URGENT** | Medically Necessary Fertility Preservation  
We will contact your patient within 24 hours

### Referral to:

- Vanessa Bacal, MD, MSc, FRCSC
- Ellen Greenblatt, MDCM, FRCSC, FACOG (REI)
- Claire Jones, BSc, MD, FRCSC
- Kimberly Liu, MD, FRCSC, MSL
- Nigel Pereira, MD, FACOG
- Miguel Russo, MD, FRCSC
- Heather Shapiro, MD, FRCSC
- Nurse Practitioner for Egg Freezing Consultation
- First Available

The MSF team also includes reproductive endocrinology and infertility fellows and a nurse practitioner.  
If more information is required, please attach documents.

<b>PATIENT DEMOGRAPHICS (as per health card):</b> Affix Label if possible Previous patient of Mount Sinai Fertility? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ DOB: _____ HC #: _____ Address: _____ Phone: _____ Email: _____ Primary Care Practitioner: _____ Preferred Name: _____ Pronouns: _____	(if applicable) <b>PARTNER(S) DEMOGRAPHICS (as per health card):</b> Affix Label if possible <input type="checkbox"/> Not applicable Name: _____ DOB: _____ HC #: _____ Address: _____ Phone: _____ Email: _____ Primary Care Practitioner: _____ Preferred Name: _____ Pronouns: _____
<b>Interpreter Requirements:</b> _____	

Referring practitioner: \_\_\_\_\_ Billing #: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_

- Infertility
- Sperm Banking\*
- Preimplantation Genetic Diagnosis
- Recurrent Pregnancy Loss
- Egg Freezing\*
- Donor Sperm / Donor Egg

*\*(If Egg freezing is for oncology or medical need, please select Fertility Preservation above)*

**Clinical Details:** \_\_\_\_\_

\_\_\_\_\_

*Please include any relevant investigations and results for the patient and, if applicable, the partner(s): previous fertility testing & treatments, bloodwork results from <1 year, ultrasounds, semen analysis, genetic testing, and abdominal or pelvic surgery reports.*

**Fertility Preservation** – Oncology/Medical Need: Please attach all relevant notes/reports.  
**Please note:** Sedation is provided in an outpatient setting without anesthesiologists present therefore egg retrieval cannot be performed safely in patients with a BMI >=40 or beyond ASA Class I-II. The age limit for Egg Freezing for Oncology patients is 43.

Oncology Treatment Start Date: \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

Chemotherapy  
  Radiation Therapy  
  Surgery  
  Treatment Completed

**Mount Sinai Fertility will contact your patient with the appointment date and time, including any instructions for the appointment.**