

- Toronto
- Mississauga
- Vaughan

Patient Referral

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

Oncology Treatment Start Date ____/____/____ Diagnosis _____

Chemotherapy Radiation Therapy Surgery Treatment Completed

i Please attach all relevant notes/reports and include any relevant investigations and results.

Referral to:

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

Patient Demographics (as per health card) Affix Label if possible

Name _____ Preferred Name _____ Pronouns _____

DOB ____/____/____ HC# _____ Primary Care Practitioner _____

Phone _____ Email _____ Address _____

(If applicable) Partner(s) Demographics (as per health card) Affix Label if possible

Name _____ Preferred Name _____ Pronouns _____

DOB ____/____/____ HC# _____ Primary Care Practitioner _____

Phone _____ Email _____ Address _____

Previous patient of Mount Sinai Fertility? Yes No Not applicable

Interpreter requirements _____

Referring practitioner _____ Billing# _____

Phone _____ Fax _____ Email _____

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

*If for oncology or medical need, please select URGENT above.

Please note: Sedation provided in an outpatient setting without anesthetists therefore egg retrieval cannot be performed safely in patients with a BMI >=40 or beyond ASA Class I-II.