

**Patient Referral Form**

**Date:** \_\_\_\_\_

Patient Information/ Label

Partner Information/ Label

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**Referring Physician Information**

Name: Address: Telephone: Fax: Billing Number:
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**Referral To:**

- Dr. Pratibha Vasudeva                       First available physician

**Reasons for Referral:**

**Infertility**

- Infertility     Recurrent Pregnancy Loss

**General Gynecology**

- Pediatric/Adolescent Gynecology               IUD Insertion                       PCOS  
 Menopause/Perimenopausal Concerns       PAP Smear                               Contraception Counselling

Other: \_\_\_\_\_

**Please enclose any relevant blood work, imaging, operative reports or consultations**