CHARM FERTILITY

CENTRE FOR HUMAN ASSISTED REPRODUCTIVE MEDICINE

Patient Referral Form

Date: ______________________

Patient Information/ Label

Partner Information/ Label

Patient Information/ Label	Partner Information/ Label

Referring Physician Information

Name:
Address:
Telephone:
Fax:
Billing Number:

Referral To:

- ☐ Dr. Sherine Rahal
- ☐ 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

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