HEARTLAND FERTILITY

Patient Referral Form

PATIENT LABEL (INTENDED CARRIER) / PARTNER LABEL [IF APPLICABLE SPERM / EGG PROVIDER]

Today's Date DD MM YYYY

☐ **URGENT: Oncology or other medically necessary fertility preservation**
Please attach all notes / reports.
Patient will be contacted within 24 hours.

Referring Physician

Name

Physician Number

Street Address

City

Province

Phone

Fax

Email

Patient Information

Name (as listed on MB Health Card)

Preferred Name

MB Health #

PHIN (9 digit #)

Date of Birth DD MM YYYY

Phone

E-mail

Biological / Assigned Sex
- ☐ Female
- ☐ Male
- ☐ Other _____

Preferred Pronouns
- ☐ She / Her
- ☐ He / Him
- ☐ They / Them
- ☐ Other _____

☐ **BMI >30**

Partner Information

Name (as listed on MB Health Card)

Preferred Name

MB Health #

PHIN (9 digit #)

Date of Birth DD MM YYYY

Phone

E-mail

Biological / Assigned Sex
- ☐ Female
- ☐ Male
- ☐ Other _____

Preferred Pronouns
- ☐ She / Her
- ☐ He / Him
- ☐ They / Them
- ☐ Other _____

Reason(s) for Referral

Infertility
- ☐ In Vitro Fertilization
- ☐ Intrauterine Insemination
- ☐ Recurrent Pregnancy Loss
- ☐ Fertility Counselling
- ☐ Egg / Sperm / Embryo Freezing
- ☐ Unexplained Fertility
- ☐ Surgical Infertility
- ☐ Donor Egg / Sperm (Anonymous)

Gynecology
- ☐ Abnormal Uterine Bleeding
- ☐ Tubal Reversal Surgery
- ☐ Minimally Invasive Surgery
- ☐ Other _____

Comments

Once we receive your referral by fax, we will contact your patient to arrange a consultation.

701 – 1661 Portage Avenue, Winnipeg, MB R3J 3T7 | **T: (204) 779-8888** | **F: (204) 779-8877**