HEARTLAND FERTILITY

Hysteroscopy Referral Form

PATIENT LABEL

Today's Date DD MM YYYY

Referring Physician

Name

Billing 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 >40**

Results Included

- ☐ HSG (Hysterosalpingogram)
- ☐ Ultrasound
- ☐ Labs

Comments

Please ensure that a Pre-Op History and Physical are attached to the referral.

Upon receiving your referral, we are committed to contacting your patient within 2 business days to book their appointment and complete their hysteroscopy procedure within 2 weeks.

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