Regional Fertility Program
The Prelude Network

400, 2000 Veteran's Place NW
Calgary, AB T3B 4N2
Office 403.284.5444 | **Fax** 403.284.9293

regionalfertilityprogram.ca

REFERRAL FORM **Please fax completed form to 403-284-9293**

Referring Physician _____ PRAC ID _____

Office Address

_____
street city province postal code

Office Phone _____ Office Fax _____

PATIENT INFORMATION: Please include name, DOB, PHN, and contact information.

Patient:	Partner (if applicable):

Referral will be triaged to the earliest available appointment for one of our practitioners.

REASON FOR REFERRAL (check all that apply)

In Vitro Fertilization (IVF)	Ovulation Induction	Donor Sperm
Male Factor Infertility	Unexplained Infertility	Donor Egg
Previous Vasectomy	Recurrent Pregnancy Loss	Surrogacy
Previous Tubal Ligation	Preimplantation Genetic Testing	Fertility Preservation

SUPPORTING DOCUMENTATION
Please include copies of the following investigations if applicable:

Investigations
- Hysterosalpingogram / Sonohysterogram
- Pelvic ultrasound
- Anti-Mullerian Hormone
- Day 3 FSH and estradiol
- Luteal phase progesterone
- Rubella titre
- Blood group, Rh factor, antibody screen
- Any gynecological surgery reports
- Previous IVF cycle records (stimulation sheet and embryology records)
- Semen analysis and anti-sperm antibodies

Comment: _____

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Physician signature: _____