ALBERTA REPRODUCTIVE CENTRE

Referral Form

#201, 17203 – 103 Avenue NW
Edmonton AB, Canada T5S 1J4
P 1 (587) 442-0461 | F 1 (587) 442-2757
ALBERTAFERTILITY.CA

Patient Information		
Legal Name *(first and last)*		**Chosen Name**
DOB *(MM/DD/YYYY)*	**Email**	
PHN # *(please note if military)*	**Phone** *(Home)*	**Phone** *(Mobile)*
Partner Name *(if applicable)*		
Address		

Referring Provider Information	
Referring Provider Name	**Phone** *(Business)*
Practice ID #	**Fax** *(Business)*
Referring Provider Clinic and Address	
Referring Provider Signature	

☐ **Infertility Consultation**	Other Services		

Services may also include, but are not limited to:
• Investigations
• Surgery
• Treatment
  ○ Ovulation Induction
  ○ Controlled Ovarian Stimulation
  ○ IUI
  ○ IVF
  ○ Preimplantation Genetic Testing
  ○ Donor Sperm & Eggs
  ○ Fertility Preservation
  ○ Egg and Sperm Freezing
	☐	**NIPT**	**LMP** *(MM/DD/YYYY)*
			EDC by US *(MM/DD/YYYY)*

	☐	**Carrier Screening**	
	☐	**Semen Analysis**	
	☐	**Registered Psychologist Consultation** *Specializing in Reproductive Mental Health*	
	☐	**Registered Dietitian Consultation** *Specializing in Reproductive Health*	

Patient History *(Please send the patient's medical history. No investigations are necessary prior to referral; however, if any have been done, please attach them to the referral.)*