



PATIENT REFERRAL

FAX: 905-823-2013

Confirmation of receipt of completed referral will be sent to referring doctor's office.

Referral to:

Shannon Moore, MSc, MD, FRCSC
800 Southdown Rd, Mississauga, ON

Date: (dd/mm/yyyy) _____

The MSF team also includes reproductive endocrinology and infertility fellows and a nurse practitioner.

REFERRING PRACTITIONER: _____ **Billing #:** _____

Phone: _____ Fax: _____

Email: _____

PATIENT DEMOGRAPHICS (as per health card):

(Mandatory requirements for appointment booking)

Previous patient of Mount Sinai Fertility? ☐ Y/☐ N

Name: _____

DOB: _____

HC #: _____

Address: _____

Phone: _____

Email: _____

PARTNER DEMOGRAPHICS (as per health card):

(Mandatory requirements for appointment booking)

☐ N/A

Name: _____

DOB: _____

HC #: _____

Address: _____

Phone: _____

Email: _____

☐ Infertility

☐ Recurrent Pregnancy Loss

☐ Sperm Banking

☐ Preimplantation Genetic Diagnosis

☐ Donor Sperm / Donor Egg / Gestational Carrier

☐ **Clinical Details:** _____

Please include, if available, any relevant investigations and results for the patient and, if applicable, the partner: previous fertility testing & treatments, bloodwork results from <1 year, ultrasounds, semen analysis results, genetic testing, and abdominal or pelvic surgery reports.

☐ **Fertility Preservation – Oncology/Medical Need** please attach consult notes, pathology & surgery reports. Specific details of the planned treatment (ie. Chemo drugs) and timelines will help expedite urgent care. **Please note: Egg retrieval cannot be performed safely in patients with a BMI >40 or beyond ASA class I-II. Sedation is provided in an outpatient setting without anesthesiologists present.**

Diagnosis: _____

☐ Chemotherapy

☐ Radiation Therapy

☐ Surgery

☐ Treatment completed

Details: _____ **Start date:** _____