OTTAWA FERTILITY CENTRE
CENTRE DE FERTILITÉ D'OTTAWA

Oncology Referral for Fertility Preservation

DATE: _____

FAX COMPLETED REFERRAL TO 613 225-9736.

PATIENT INFORMATION / DÉTAILS SUR LE OU LA PATIENTE	
Name / Nom:	
DOB (yyyy/mm/dd): **DDN (aaaa/mm/jj):**	
Address / Adresse:	
Phone No.: **Numéro de telephone:**	
Health No.: **Nº de carte OHIP:**	
Other ID / Autre:	
☐ OHIP ☐ Blue Cross ☐ Out-of-Province ☐ Other	

REFERRING PHYSICIAN / MÉDECIN DEMANDEUR	
Name / Nom:	
MOHLTC Billing No.: **Nº de facturation du MSSLD:**	
Phone No.: **Numéro de telephone:**	
Fax No.: **Télécopieur:**	

Cancer Diagnosis: _____

Previous Cancer Treatment
☐ Yes ☐ No

Dates and Treatments: **First day of last menstrual period:** _____

_____

_____

_____

_____

_____

Current Treatment Plan:

Start Date: _____

Treatment Regimen: _____

_____

_____

_____

Complete Lab Services • Ultrasound • Fertility Medications • Surgery • Counselling

955 Green Valley Crescent, Ottawa, Ontario K2C 3V4
Phone: (613) 686-3378 | Fax: (613) 225-9736 | www.conceive.ca | www.fertilityconnect.ca