

# Patient Referral Form

All fields marked with \* must be completed prior to submission



## ● PATIENT INFORMATION - as per health card

Patient Name \*

Date of Birth \*

Health Card # (OHIP / BC CareCard) \*

Patient Phone \*

Patient Email \*

Has this patient been seen at Twig before? \*

Yes  No

Does this patient have previous IVF history? \*

Yes  No

## ● REFERRING PROVIDER

Provider Name\*

Billing # \*

Date \*

Phone \*

Fax \*

Email

City / Province

Postal Code

## ● PREFERRED PHYSICIAN

ON | Fax to: 416-987-2256 | hello@twigfertility.com

No preference

Dr. Hadas Ganer Herman

Dr. Rhonda Zwingerman

Dr. Alyson Digby

Dr. Ruth Ronn

Dr. Argyrios Kolokythas

BC | Fax to: 778-693-3961 | hello.bc@twigfertility.com

No preference

Dr. Alice Buwembo

Dr. Amrita Pooni

## ● FAMILY DOCTOR - if different from referring provider

Family Doctor Name

Fax

Phone

## ● REASON FOR REFERRAL

Please check all that apply \*

Fertility

Egg, Sperm or Embryo Freezing

Other

LGBTQ2S+ Family Building

Recurrent Pregnancy Loss

Fertility Check

Donor Sperm/Eggs or Gestational Surrogacy

## ● ADDITIONAL INFORMATION

Please attach any relevant prior testing or cycle records. Prior testing is not required.

## ● REFERRING PHYSICIAN - For Office Use

Referring Physician Signature

Print Name

Billing #

Fax

Date

### Toronto Midtown

313 Eglinton Avenue West  
Toronto, ON  
M5N 1A1  
Phone: (416) 855-8944  
Fax: (416) 987-2256

### Toronto Downtown

130 King St West  
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M5X 2A2  
Phone: (647) 699-3808  
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### Vancouver

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