Eastern Health

Child/Women's Health Program

# Gynecologic Reproductive Endocrinology and Infertility Referral

Incomplete referrals will be returned. ☐ See Referral Criteria.

AD1820 2330 10 2022

Name:

HCN:

Date of Birth:

**Referring Health Authority:**

☐ Eastern Health (Rural) ☐ Eastern Health (City) ☐ Central Health ☐ Western Health ☐ Labrador Grenfell Health

**Patient Information:**

Telephone:_____ Email: _____

Mailing Address:

Does the patient require an Interpreter? ☐ No ☐ Yes - Language?_____

**Partner Information (if applicable)** ☐ **Consent Given**

Name: _____ HCN:_____

Date of Birth: _____ Family Physician: _____

## Primary Reason for Referral – Please check(√) all that apply

### Infertility and Reproductive Endocrinology

☐ Fertility preservation prior to cancer treatment *(no testing required prior to being seen)*

☐ Fertility preservation prior to other medical/surgical treatment
Specify:_____

☐ Oocyte Cryopreservation (social)

☐ Transgender care
- ☐ Sperm Cryopreservation
- ☐ Oocyte Cryopreservation

☐ Unable to conceive after regular *(2-3x/week)* unprotected intercourse

☐ Recurrent pregnancy loss

☐ Low sperm count

☐ Low ovarian reserve

☐ Donor sperm insemination

☐ Premature Ovarian Insufficiency/Menopause

☐ Other: _____

### Gynecology

☐ Endometriosis
☐ Menstrual Dysfunction
☐ Polycystic Ovarian Syndrome /Ovulatory Dysfunction
☐ Reproductive Surgery
☐ Other:_____

### Obstetrics

☐ Prenatal
☐ Other: _____

**Additional Clinical Information:**

Gara_____ Para_____ Abortion_____ Ectopic Pregnancy_____

Months of unprotected regular intercourse: ☐ 6-12 months ☐ 12-24 months ☐ Greater than 24 months

**Include any other significant medical information/special considerations:**

**Referring Practitioner's:**

Name: _____ Date of Referral: _____DD/MONTH/YYYY_____

Signature: _____ Telephone: _____

**NL Fertility Services**

Majors Path, St John's, NL Telephone: (709) 777-7444

Submit Form