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## Referral Form: Appointments within 2 weeks

*On-site Laboratory    On-site Ultrasound*

Patient Name: \_\_\_\_\_

Health Card Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

DOB:    /    /

**Reason for referral:** *(Please attach patient documentation or investigations):*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referring Doctor Name & Signature:

\_\_\_\_\_ OHIP Billing # \_\_\_\_\_

<p><b>Infertility Treatment</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Infertility investigations</li> <li><input type="checkbox"/> Cycle Monitoring</li> <li><input type="checkbox"/> Advanced Semen Analysis</li> <li><input type="checkbox"/> Sonohysterogram</li> <li><input type="checkbox"/> Tubal Patency Testing</li> <li><input type="checkbox"/> Intrauterine Insemination</li> <li><input type="checkbox"/> IVF ± ICSI</li> <li><input type="checkbox"/> Donor Insemination, Egg Donation &amp; Gestational Carrier</li> <li><input type="checkbox"/> Recurrent Pregnancy Loss</li> <li><input type="checkbox"/> Tubal Re-anastomosis Surgery</li> <li><input type="checkbox"/> Fertility Preservation (Sperm, Oocytes, Embryos)</li> </ul>	<p><b>General Gynecology</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> PAP Smear</li> <li><input type="checkbox"/> IUD Insertion</li> <li><input type="checkbox"/> Birth Control</li> <li><input type="checkbox"/> Abnormal Uterine Bleeding/ Post-Menopausal Bleeding</li> <li><input type="checkbox"/> Endometrial Ablation</li> <li><input type="checkbox"/> Endometriosis</li> <li><input type="checkbox"/> Endometrial Biopsy</li> <li><input type="checkbox"/> Pelvic &amp; Transvaginal Ultrasound</li> <li><input type="checkbox"/> Uterine Fibroids, Polyps, Septum</li> <li><input type="checkbox"/> Management of Ovarian Cysts</li> </ul>
<p><b>Early Pregnancy Care Unit</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pregnancy Test (same day results)</li> <li><input type="checkbox"/> Pregnancy Ultrasound (Dating &amp; viability)</li> <li><input type="checkbox"/> Early Pregnancy Bleeding Evaluation</li> </ul>	<p><b>Reproductive Endocrinology</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Management of Menopause / HRT</li> <li><input type="checkbox"/> Management of Menstrual Disorders</li> <li><input type="checkbox"/> PCOS (Investigations &amp; Management)</li> <li><input type="checkbox"/> Premature Ovarian Insufficiency</li> </ul>
<p><b>Andrology &amp; Men's Health</b></p> <ul style="list-style-type: none"> <li style="width: 50%;"><input type="checkbox"/> Low libido</li> <li style="width: 50%;"><input type="checkbox"/> Erectile dysfunction</li> <li style="width: 50%;"><input type="checkbox"/> Ejaculatory dysfunction</li> <li style="width: 50%;"><input type="checkbox"/> Abnormal sperm analyses</li> </ul>	