C.W. WIEBE MEDICAL

www.cwwiebemedical.ca

FERTILITY Referral Form

Date: _____

Patient Name:
Address:
MB Health #: PHIN: Date of Birth:_____/_____/_____
Home Phone: Work Phone: M D Y

Partner Name:
Address:
MB Health #: PHIN: Date of Birth: _____/_____/_____
Home Phone: Work Phone: M D Y

Referring Physician:

Phone number: Fax:
Address:

Referral to:

○ Dr. Sahar Alhayjaa ○ Dr. Ashley Dyson ○ First Available Physician

Investigations:
Please include all relevant consultations and investigations performed in the last 3 months for female and male patients and include with your referral letter.

Female Fertility Patients

- ○ Day 3 FSH
- ○ Hepatitis B, C
- ○ Pelvic Ultrasound
  - ☐ Completed
  - ☐ Pending
- ○ TSH, Prolactin
- ○ Rubella
- ○ Surgery Reports (if applicable)
- ○ Hysterosalpingogram
  - ☐ Completed
  - ☐ Pending
- ○ HIV 1 & 2
- ○ VDRL
- ○ CBC
- ○ Rh Prenatal & Screen
- ○ Other:

Male Fertility Patients

- ○ HIV 1 & 2
- ○ Semen Analysis
- ○ Hepatitis B, C
- ○ VDRL
- ○ Blood Type Rh
- ○ Other:

Comments:

Referrals can be faxed to: 204-325-4594 ***For questions phone: 204-331-2344***
C.W. Wiebe Medical Centre will contact your patient, to arrange a consultation once a complete referral has been received.