First Steps Fertility

REFERRAL FOR INFERTILITY WORKUP & MANAGEMENT

Date: _____

Fax To: **Dr. F Weisberg**

Fax #: **416-924-7099**

Attention: _____

Patient Name: _____

Patient Contact Tel #: _____ Patient Email: _____

Total No. Of Pages: _____

Referring Physician's Name: _____

Tel: _____ Fax: _____ Ohip #: _____

Please See _____ (Patients Name), _____ year old, G____ P _____

and _____ (Partners' Name, if applicable) for the following fertility concerns

Attached, please find enclosed the following information (check mark), if available:

- Testing of ovarian reserve (day 3 FSH, extradio level)
- Endocrine screen (TSH, Prolactin)
- Structural assessment (pelvic ultrasound, relevant operative reports, hysterosalpinogogram or sonohysterogram)
- Semen Analysis