



Referral Form / VICTORIA CLINIC

Patient Name _____ Date of Birth _____

Partner Name (if applicable) _____ Date of Birth _____

Home Phone _____ Work Phone _____ Cell Phone _____

Personal Health Number _____

Address _____

Email address _____

Referring Physician's Name _____ MSP Number _____

Office email address _____ Can we contact you by email? YES / NO

Victoria Office Dr. Ginevra Mills Dr. James Graham Clinic to Designate

Reason for referral

- Infertility Donor Egg Egg Freezing
- Donor Sperm Recurrent Miscarriage Surrogacy
- Transgender care Pre-implantation Genetic Diagnosis
- URGENT Fertility Preservation/Cancer

Relevant History:

**Please include all relevant investigations and records with your referral
and fax this form to our office at the fax number provided below.**

214-911 Yates St, Victoria, BC, V8V 4X3

tel: 250-410-1664 fax: 604-559-9951

**To download more printable referral forms or to submit a referral online:
olivefertility.com/referring-physicians**