REFERRAL FORM

FLANNIGAN FERTILITY

Date of Referral: _____

Physician Information:

Referring Doctor Name: _____

Referring Doctor Billing Number: _____

Patient Information:

Surname: _____ Given Name: _____

Date of birth: _____ Personal Healthcare Number: _____

Telephone: _____ Email: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Reason for Referral: _____

- ☐ Infertility
- ☐ Peyronies Disease
- ☐ Erectile Dysfunction
- ☐ Vasectomy
- ☐ Vasectomy Reversal
- ☐ Low Testosterone
- ☐ Other Sexual Dysfunction

History:

Thank you for the opportunity to care for your patient. Please fax or email this form (below).

2775 Laurel Street, 6th Floor, Vancouver, BC V5Z 1M9

Tel: 604-875-5003 Fax: 604-875-5604

info@flanniganfertility.ca