

REFERRAL FORM



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

Confidential Warning: Documents accompanying this form contain confidential information and are intended for a specific individual and purpose. This information is private by law. If you are not the intended recipient and have received this communication please notify sender by phone.