Dynacare®
Genetics and Specialty Services

Dynacare – Fertility Referral Form

Please fax referral to 450-901-3076

Your patient will be contacted within 10 business days of receiving the referral. They will receive instructions on booking an appointment by telephone/email/text. If there are any changes to your patient's demographic information, please inform us as soon as possible at: genetics@dynacare.ca.

☐ Your patient consents to receive communications by email.

Patients information

	Partner 1	Partner 2 (if necessary)
Patient Name		
DOB (MM/DD/YYYY)		
Biological Sex at Birth (M/F/Other)		
Gender Identity (M/F/Non-Binary/Other)		
Health Card Number		
Address		
Postal Code		
Phone (Mobile preferred) & Email		

Interpreter required: ☐ Yes ☐ No Language: ____________________

Referring doctor/health care provider: ____________________

Clinic Address/ Phone/ Fax ____________________

Billing# ____________ Email: ____________________

Reason for referral

☐ Multiple miscarriages (No of miscarriages: ________)

☐ Patient or partner with previous pregnancy affected by birth defect or other genetic condition

☐ Infertility unknown etiology

☐ Infertility known etiology

Female factor:

- ☐ Primary amenorrhea
- ☐ Premature ovarian failure (POF)
- ☐ Premature menopause
- ☐ Advanced maternal age

Male factor:

- ☐ Azoospermia
- ☐ Oligoasthenoteratozoospermia (OAT)
- ☐ Congenital absence of the vas deferens (CAVD)

☐ Abnormal genetic results

- ☐ Karyotype/microarray
- ☐ Fragile X
- ☐ Y microdeletion
- ☐ CFTR mutation
- ☐ Other ____________________

☐ Positive carrier screen:
Condition(s): ____________________

☐ Personal and/or Family History of known condition:

Relationship to patient: ____________________

Name of affected person: ____________________

DOB (MM/DD/YYYY): ____________________

☐ Carrier/ethnic related screening

☐ Consanguinity

☐ PGT (Please include results if possible)
Reason: ____________________
Other: ____________________

Additional relevant clinical and/or family history