Dynacare®
Genetics and Specialty Services

Dynacare – Fertility Referral Form

Please fax completed form and following required prenatal records to 450-901-3076
Please ensure your patient is aware of referral before sending referral
Missing records may result in delay of patient's appointment

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		

Interpreter required: ☐ Yes ☐ No Language: _____

Referring doctor/health care provider: _____

Clinic information and 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:
_____

Name of affected person: _____

Relationship to patient: _____

DOB (MM/DD/YYYY): _____

☐ Carrier/ethnic related screening

☐ Consanguinity

☐ PGT (Please include results if possible)
Reason: _____

☐ Other: _____

Additional relevant clinical and/or family history

_____

_____

_____

_____

_____