Referral Form / KELOWNA CLINIC

OLIVE
fertility centre
KELOWNA

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 _____

Referring physician phone number _____

Referring physician fax number _____

Kelowna Office ☐ Clinic to Designate ☐ Dr. Katherine Wise ☐ Dr. Kim Daniel ☐ Dr. Jill Griffiths

☐ Dr. Glenn Benoit

Reason for referral

☐ Infertility ☐ Donor Egg ☐ Egg Freezing

☐ Donor Sperm ☐ Sperm Freezing ☐ Surrogacy

☐ Pre-implantation Genetic Diagnosis ☐ Recurrent Miscarriage ☐ Transgender care

☐ URGENT Fertility Preservation/Cancer ☐ OB / GYN

Relevant History: _____

_____

_____

_____

Please include all relevant investigations and records with your referral.

202-1630 Pandosy St., Kelowna, BC, V1Y 1P7

tel: 250-861-6811 *fax:* 250-861-6814

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