



# Refer to Pollin Ottawa

Please select one of the two referral options provided below. Once completed, Pollin will promptly contact the patient regarding appointment specifics. We look forward to providing the best care for your patient.

- 1. **Refer to Pollin via Fax:** Fill out this form and fax to (437) 702-0876
- 2. **Refer to Pollin via Email:** Fill out this form and send to [referrals@pollinfertility.com](mailto:referrals@pollinfertility.com)

## Patient referral form

*\*all fields must be completed prior to submission*

### PHYSICIAN INFORMATION

|                             |                      |
|-----------------------------|----------------------|
| Referring physician (Name)* | Date *               |
| <input type="text"/>        | <input type="text"/> |
| Billing # *                 | Phone Number *       |
| <input type="text"/>        | <input type="text"/> |
| Fax                         | Email                |
| <input type="text"/>        | <input type="text"/> |

### Referral to:

- ☐ Kim Garbedian, MD, FRCSC (Virtual Only)
- ☐ Katrina Hickey, MD, FRCSC
- ☐ Joanne Hickey, MD, FRCSC
- ☐ First available appointment

### PATIENT DEMOGRAPHICS (AS PER HEALTH CARD):

|                                                                        |                      |
|------------------------------------------------------------------------|----------------------|
| Name *                                                                 | DOB *                |
| <input type="text"/>                                                   | <input type="text"/> |
| OHIP# *                                                                | Phone *              |
| <input type="text"/>                                                   | <input type="text"/> |
| Sex at Birth * <input type="radio"/> Male <input type="radio"/> Female |                      |

### Select the specific service you are referring your patient to:

|                                                        |                                                     |
|--------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Fertility                     | <input type="checkbox"/> Second Opinion Case Review |
| <input type="checkbox"/> Pregnancy Loss                | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Egg, Sperm or Embryo Freezing | <input type="text"/>                                |
| <input type="checkbox"/> LGBTQ+ / Third Party          |                                                     |

### Additional Comments

**Thank you for entrusting your patient's fertility care with Pollin.**

Pollin will contact your patient with the appointment date & time, including any instructions for the appointment.

