Referral Form

Please fax to 306-653-5200

Dr. Allison Case & Dr. Adrian Gamelin

Referrals are seen by the first available physician.

Patient Information / Label

Partner Information / Label

Referring Physician

Name: _____ Physician Billing #: _____

Address: _____

_____

Phone: _____ Fax: _____

Reason for Referral

_____

_____

_____

* Please attach any previous investigations (such as bloodwork, semen testing, hysterosalpingogram, operative report).

Signature: _____ Date: _____

Aurora Reproductive Care

River Centre I, 4th Floor
405 - 475 2nd Avenue South, Saskatoon, SK S7K 1P4

t: 306 653 5222 **f:** 306 653 5200

www.auroraivf.ca