HART FAMILY MEDICAL
AND IUD CLINIC

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Vasectomy Referral Form

I am referring:

Patient Name:	Date of birth:
AHC #:	Phone #:
Address:	Email:

Referring MD:	
PracID:	
Phone #:	Fax #:

Patient Medical History

☐ Healthy
☐ Conditions: _____

Patient BMI: ☐ <40 ☐ >40

Medications:_____

Allergies: _____

We will contact your patient directly within 7 days for booking a vasectomy **consultation**. After the procedure is done, the referring physician will be provided with a consult letter. Thank you for your kind referral!

Please fax completed form to: (403) 452 - 7311