



ASALI HEALTH · PROVIDER REFERRAL FORM

Secure fax: (866) 460-7415 Admin contact: hello.asalihealth@gmail.com (general inquiries only — no PHI by email)

*Thank you for thinking of Asali Health for your patient. This form takes most providers under five minutes — the fastest way to fill in the clinical history sections is to attach existing chart notes rather than retype them. Fields marked with * are required; everything else is helpful but optional.*

1 PATIENT INFORMATION

Last name *	First name *	Date of birth (YYYY-MM-DD) *
Health card / PHN	Province (ON or BC) *	Pronouns
Phone *	Email *	
Preferred contact method		
☐ Secure message	☐ Phone	☐ Video, if clarification is needed

2 REFERRING PROVIDER

Provider name *	Designation *	Registration number
Clinic / organization *	Province *	
Phone *	Secure fax for report *	Administrative email

3 REFERRAL PURPOSE

Select all that apply — we'll confirm the clinical plan with you before proceeding.

- | | |
|---|---|
| ☐ Preconception health / fertility planning | ☐ Female fertility evaluation |
| ☐ Male fertility evaluation | ☐ Review of existing investigations |
| ☐ Clinical review of proposed conventional testing | ☐ Imaging assessment / requisition request |
| ☐ Specialist referral or triage question | ☐ Other (specify below) |



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continued

Specific clinical question / assistance requested *

Anything you'd like Asali Health to consider (optional)

4 ELIGIBILITY CONFIRMATION

- ☐ Patient is 18 years of age or older ☐ Patient is aware of the \$149 private consultation fee
- ☐ Patient is clinically stable and suitable for a focused virtual consultation ☐ Patient will be in Ontario or BC during care
- ☐ I will retain responsibility for the patient's ongoing care ☐ Patient consents to being contacted by Asali Health

Investigations are ultimately guided by our NP's clinical judgement, and we'll always loop you in on the plan.

5 FERTILITY & PRECONCEPTION BACKGROUND

Required fields are marked *. Everything else, fill in if it's readily on hand.

Current goal / context

- ☐ Preconception — not yet trying ☐ Currently trying to conceive ☐ Considering / receiving assisted care

Duration trying to conceive *

Last menstrual period *

If readily on hand (optional):

Cycle pattern / typical length

Partner evaluation completed?

Previous fertility care

Pregnancy history (G/P/losses)

Current medications and supplements



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continued

Relevant history (fertility, menstrual, reproductive, medical, surgical, family) — attach chart notes if available, or summarize briefly below

6 PREVIOUS INVESTIGATIONS & ATTACHMENTS

The fastest way to get us up to speed: attach documentation directly to this referral instead of re-entering it above. Fax to (866) 460-7415, or include as attachments if submitting electronically. Check all that you're including:

- | | | |
|---|---|---|
| ☐ Laboratory results | ☐ Imaging reports | ☐ Semen analysis |
| ☐ Medication / supplement list | ☐ Cycle tracking information | ☐ Consultation letters |
| ☐ Other (specify below) | | |

Relevant previous investigations and dates (if not attached)

7 CONFIRMING THE REFERRAL

By submitting this referral, I confirm the information provided is accurate to the best of my knowledge; the patient has been informed of the purpose and private fee for this focused consultation; the patient has consented to Asali Health contacting them and sharing the resulting report with me; and I will remain responsible for the patient's ongoing care after the focused consultation is complete.

Provider name *

Provider signature / initials *

Date (YYYY-MM-DD) *

A quick note on scope

Asali Health offers focused virtual fertility consultation and diagnostic support. We're not set up for emergencies or in-person urgent care, and each investigation we order needs a clear, independent clinical indication. DUTCH testing isn't currently part of what we offer.

FOR ASALI HEALTH INTERNAL USE ONLY

Date received

Triaged by

Consult booked