Date: _____

Dr. Roland Sing
Gentle Procedures Clinic
77 Queensway West
Suite 310
Mississauga, ON
L5B 1B7

RE: VASECTOMY REFERRAL

Patient Name:
DOB:
OHIP #:
Email:
Phone:

Physician Name:
Phone:
Fax:
OHIP Billing #:

REFERRALS WILL BE RETURNED IF ABOVE INFORMATION IS MISSING IN WHOLE OR IN PART.

☐ Consult ☐ Consult and Procedure

Dear Dr. Sing:

Please review the above-named patient for permanent sterilization by way of vasectomy. He is aware of other contraceptive alternatives. He has confirmed that he wishes to have no further biological children of his own.

Past Medical History
☐ Healthy
☐ Other conditions: _____

Medications
☐ None
☐ Prescription meds: _____

Allergies
☐ None
☐ Allergies: _____

Signature: _____ MD