

**PATIENT REFERRAL**

Fax to: 905-721-3558

Attn: NEW PATIENT COORDINATOR

Patient Information:

*Affix patient label if possible*

Name:

Address: Email:

OHIP #:

DOB: Phone:

Reason for Referral:

* Primary Infertility Secondary Infertility Fertility Assessment Only
* Recurrent loss ο Genetics ο PCOS ο Endometriosis ο Male factor
* Donor Egg ο Egg freezing ο Other: ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this patient been seen by DFC before? Y N

Has this patient undergone fertility treatment before? Y N

Referring Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing #:­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patients will be contacted within 5 business days with an appointment date.**

*117 King Street East 2nd Floor – parking is behind the building, off of Charles St.*