ReproMed FERTILITY

Referral Note

Insert Patient Label Here
(Or Fill Out the Section Below)

Referring Physician Information

Dr:_____

Address:_____

City:_____ Prov.:_____Postal:_____

Phone:_____ Fax:_____

Email: _____

Patient Information *(if no patient label):*

Name:_____

DOB:_____

H.C.N:_____

Phone:_____

Cell:_____

Street:_____

City / Prov:_____

Postal:_____

Email:_____

To Book Your Appointment You May:

- Fax this to 416-233-8360
- Scan it and email to:
patientservices@repromed.ca
- Call Us Directly at 416-233-8111 ext 1

Dear Fertility Specialist, Date:_____

I am referring the following patient for the following reasons:

____ Years Primary Infertility ____ Years Secondary Infertility

____ Anovulation ____ Irregular Periods ____ Tubal Occlusion

____ Endometriosis ____ Ovarian Failure ____ Male Factor

____ Sperm Donation ____ Surrogacy ____ IVF

____ IUI ____ Egg Donation ____ Recurrent Miscarriage

____ Preimplantation Genetic Diagnosis ____ Fertility Preservation

____ Same Sex: ____ Male ____Female

Documents Enclosed (please circle):

Semen Analysis HSG SONO Laparoscopy Other

Additional Comments:_____

_____

_____

_____
Referring Physician Signature

OHIP Billing # _____

Directions to Clinic
56 Aberfoyle Cres., Suite 300 Toronto ON M8X 2W4

We are located in Toronto at the North East corner of Bloor and Islington. With easy access from the Gardiner Expressway, 401, and 427 highways. We are just across from the Islington Subway Station. Parking is available by turning down Lomond Drive (off of Aberfolye Cres.) and accessing the lot at the end on the left.