HOPE
Fertility & Reproductive
MEDICINE CENTRE

where dreams are born

PATIENT REFERRAL FORM

Please fill in the information below and fax to: 416.609.8711– Attn: New Patient Referral (referrals@hopefertility.ca)

PATIENT DEMOGRAPHIC
(email address appreciated)

PARTNER DEMOGRAPHIC LABEL
(If possible or applicable)

Reason for Referral:
- ☐ Fertility Assessment Only
- ☐ Fertility Assessment and Treatment
- ☐ Other: _____

(Please attach any relevant investigations and previous fertility treatment information if applicable).

Has this patient been seen by the HOPE Fertility & Reproductive Medicine Centre before? ☐ Yes ☐ No

Referring Physician:	Address:
OHIP Billing #:	
Phone:	
Fax:	

PATIENT WILL BE CONTACTED WITHIN 2-4 BUSINESS DAYS WITH AN APPOINTMENT DATE