Ajax Fertility Clinic
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PATIENT REFERRAL FORM

Patient Information:	
NAME	
DOB	
HC#	
ADDRESS	
PHONE	
EMAIL	

Reason for Referral:

☐ Female fertility ☐ PCOS ☐ Recurrent Miscarriage ☐ Egg Freezing
☐ Male fertility ☐ Sperm Freezing ☐ Testing only
☐ Prenatal Genetic testing ☐ Non-traditional families (donors involved)
☐ Other: _____

We accept patients without prior testing and we are happy to provide in-house testing for individuals and couples (reproductive hormones, ultrasound, sonohysterogram, semen analysis, etc.). If available, kindly include all copies of relevant medical tests and lab results. **We are pleased to offer services in various languages, including English, French, Arabic, Mandarin, Cantonese, Tamil, and Russian.**

Referring Physician Information:	
NAME	
CLINIC / ADDRESS	
BILLING#	
CPSO#	

PLEASE FAX TO: 905-245-0522

Thank you for your referral!