



## Ajax Fertility Centre

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### PATIENT REFERRAL FORM

Patient Information:	
NAME	
DOB	
HC#	
ADDRESS	
PHONE	
EMAIL	

#### Reason for Referral: (FERTILITY check is a good enough reason!)

<input type="checkbox"/> Female fertility <input type="checkbox"/> PCOS <input type="checkbox"/> Recurrent Miscarriage <input type="checkbox"/> Egg Freezing
<input type="checkbox"/> Male fertility <input type="checkbox"/> Sperm Freezing <input type="checkbox"/> Testing only
<input type="checkbox"/> Prenatal Genetic testing <input type="checkbox"/> Non-traditional families (donors involved)
<input type="checkbox"/> <b>Other:</b>

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 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	
ADDRESS	
FAX	
BILLING#	
CPSO#	

**PLEASE FAX TO: +1 (877) 576-3878**

Thank you for your referral!