



Q U E S T

*Centre for
Reproductive Medicine*

Patient Referral

Please give this form to your doctor to complete.

Please fax referrals to **416-506-0600**

Patient Demographics

Reason for Referral

Please attach any relevant investigations or previous fertility treatment

Referring Physician: _____ Address _____

OHIP Billing #: _____

Phone _____

Fax _____

Patient will be contacted with appointment date and time.

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