Referral Form

Referring Physician

M.D./ N.P. ☐ N.D. ☐

Name

OHIP Billing # (if applicable)

CONO # (if applicable)

Fax

Phone

Email

Patient Information

Name

Date of birth DD MM YYYY

Phone

E-mail

Partner Information (if applicable)

Name

Date of birth DD MM YEAR

Phone

E-mail

Reason(s) for Referral

☐ URGENT: Oncology or other medically necessary fertility preservation. Please attach all notes / reports. Patient will be contacted within 24 hours.

☐ Infertility
☐ Donor Sperm
☐ Egg Freezing
☐ Recurrent Miscarriage
☐ Donor Egg
☐ Sperm Freezing
☐ Transgender Fertility Preservation
☐ Surrogacy
☐ Pre-Implantation Genetic Testing (PGT-A / PGT-M)

Physician Preference (if applicable): _____

Guidance

- Please include all relevant investigations and records with your referral
- Select location, then fax or email this form to:
  - ☐ Vaughan: 289.357.0101 or info@generationfertility.ca
  - ☐ Newmarket: 905.967.0512 or info@generationfertility.ca
  - ☐ Toronto West: 416.233.8360 or tw.info@generationfertility.ca
  - ☐ Waterloo: 519.570.3202 or kw.info@generationfertility.ca
- Once received, we will contact your patient to arrange a consultation
- To download more referral forms or submit a referral online visit generationfertility.ca/medical-professionals

Vaughan
955 Major Mackenzie Drive West
T: 289.357.0100 | F: 905.967.0512
info@generationfertility.ca

Newmarket
1111 Davis Drive East
T: 905.967.0852 | F: 905.967.0512
info@generationfertility.ca

Toronto West
56 Aberfoyle Crescent
T: 416.233.8111 | F: 416.233.8360
tw.info@generationfertility.ca

Waterloo
435 The Boardwalk
T: 519.570.0090 | F: 519.570.3202
kw.info@generationfertility.ca