B-627-Lyons Lane
Oakville, ON L6J 5Z7
Phone: 905-844-7238
Fax: 905-844-7256
Hours: 7 am - 4 pm
Mon. - Fri.
www.oakvillefertility.com

Oakville Fertility
& Women's Health Centre

PATIENT REFERRAL FORM

Date of Referral:_____

PATIENT'S NAME:		**Referring Physician's Name:** **Signature:**		
Address or Chart Label:		**Address or Office Stamp:**		
		Referring Physician No.:		
Health Card No.:		**VC:**		
DOB:	**Daytime Phone:**	**Evening Phone:**	**Office Phone:**	**Office Fax:**

REFERRAL TO: ☐ **Dr. Kimberly Elford**

REASON FOR REFERRAL:

- ☐ **Female infertility**
- ☐ **Male infertility**
- ☐ **Recurrent pregnancy loss**
- ☐ **Assisted reproductive therapy (IVF, intrauterine insemination)**
- ☐ **General gynecology**
- ☐ **Paediatric/adolescent gynecology**
- ☐ **Cancer patients - fertility preservation**
- ☐ **Contraception Counseling**
- ☐ **Menopause/Perimenopausal issues**
- ☐ **Other, please specify:**_____

Notes/Enclosures: (please enclose any relevant blood work, imaging, operative reports or consultations)

**** Patients will be contacted directly by our office within two weeks of receiving referrals to arrnage an appointment. If the patient has not heard from our office within this time, please call the office to ensure the referral was received.****