



Physician Referral Form

Please complete our referral form and fax it to your patient's desired clinic location (listed below). A member of our nursing team will contact your patient to review any pre-appointment questions, and schedule the in-person assessment.

Fields marked with an asterisk * are mandatory.

When to Refer Your Patient

- Female partner is 35 or older
- Trying to conceive for 6 months or more
- Irregular menses
- Known male factor
- Known tubal factor or endometriosis
- Prior fertility treatment
- Fertility concerns
- Recurrent Pregnancy Loss
- PCOS

Check your patient's desired location:

- Lakeridge Fertility (Whitby)
- Barrie Fertility (Barrie)
- Niagara Fertility (Niagara/Stoney Creek)
- TRIO KW (Kitchener/Waterloo)

Primary Patient Details

*First Name:

*Last Name:

*Date of Birth (month/day/year)

OHIP #:

Version Code:

* Main Phone #

* Email:

* Street Address:

* City:

* Province:

* Postal Code:

* Country:



Referring Physician Signature: _____

Billing #: _____

Fax: _____

PRINT Name: _____

Lakeridge Fertility
220 Dundas St W,
#404
Whitby, ON L1N 8M7

Ph: 905-493-9222
Fax: 905-493-9221

Barrie Fertility
1 Quarry Ridge Rd.,
201
Barrie, ON
L4M 7G1

Ph: 705-728-7784
Fax: 705-733-9428

Niagara Fertility
821 North Service Rd.,
103
Stoney Creek, ON
L8E 0J7

Ph: 905-662-3139
Fax: 905-662-3140

TRIO KW Fertility
430 The Boardwalk,
Suite 407,
Waterloo, ON
N2T 0C1

Ph: 519-585-1796
Fax: 519-584-0770