

**PATIENT REFERRAL**

Fax to: 416.506.0680 Attn: New Patient Coordinator ( [referrals@hannamfertility.com](mailto:referrals@hannamfertility.com) )

PATIENT DEMOGRAPHIC  
(email address appreciated)

PARTNER DEMOGRAPHIC LABEL  
(If possible or applicable)

Reason for Referral:  Fertility Assessment Only  
 Fertility Assessment and Treatment  
 Other: \_\_\_\_\_  
\_\_\_\_\_

*(Please attach any relevant investigations and previous fertility treatment information if applicable)*

Has this patient been seen by the Hannam Fertility Centre before?  Y  N

Referring Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
OHIP Billing #: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

PATIENT WILL BE CONTACTED WITHIN 2-4 BUSINESS DAYS WITH AN APPOINTMENT DATE

*The information provided will assist to determine which physician is best suited for your patient's needs.  
Your patient may be seen by Dr. Thomas Hannam, Dr. Elin Raymond or Dr. Carrie Schram.*