Please fax the completed form to 905-471-7447 or e-mail to info@tripodfertility.com. You will be contacted directly with your appointment confirmation.

Tripod Fertility Patient Self-Referral Form. All fields required.

Patient Information

PATIENT NAME:

DATE OF BIRTH:

HEALTH CARD NUMBER:

STREET ADDRESS:

CITY:

PROVINCE/TERRITORY/STATE:

POSTAL CODE/ZIP:

PATIENT E-MAIL ADDRESS:

PATIENT PHONE NUMBER:

Partner Information (if applicable)

PARTNER NAME:

PARTNER DATE OF BIRTH:

PARTNER HEALTH CARD NUMBER:

STREET ADDRESS:

CITY:

PROVINCE/TERRITORY/STATE:

POSTAL CODE/ZIP:

PARTNER E-MAIL ADDRESS:

PARTNER PHONE NUMBER:

REASON FOR SELF-REFERRAL:

HOW DID YOU FIND OUT ABOUT US?:

Thank you for your time and we look forward to meeting you!

Atria III
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Toronto, ON
M2J 5C2
Telephone: 905-201-3420
Website: tripodfertility.com