Please fax the completed form to 905-471-7447 or email to referrals@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 AND VERSION CODE ____

SEX (AS STATED ON HEALTH CARD) ____

STREET ADDRESS ____

CITY ____

PROVINCE/TERRITORY/STATE ____

POSTAL CODE/ZIP ____

PATIENT EMAIL ADDRESS ____

PATIENT PHONE NUMBER ____

PREFERRED PHARMACY ____

DO YOU HAVE PRIVATE INSURANCE: YES OR NO

Partner Information

PARTNER NAME ____

PARTNER DATE OF BIRTH ____

PARTNER HEALTH CARD NUMBER AND VERSION CODE ______________________________

SEX (AS STATED ON HEALTH CARD)____

STREET ADDRESS ____

CITY ____

PROVINCE/TERRITORY/STATE ____

POSTAL CODE/ZIP ____

PARTNER EMAIL ADDRESS ____

PARTNER PHONE NUMBER ____

PARTNER PREFERRED PHARMACY ____

DOES YOUR PARTNER HAVE PRIVATE INSURANCE: YES OR NO

REASON FOR REFERRAL

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HOW DID YOU HEAR ABOUT US? ____