CHARM FERTILITY
CENTRE FOR HUMAN ASSISTED REPRODUCTIVE MEDICINE

Patient Referral Form

Date: _____

Patient Information/ Label	Partner Information/ Label

Referring Physician Information

Name:
Address:
Telephone:
Fax:
Billing Number:

Referral To:

☐ Dr. Lamiaa Migahed ☐ Dr. Waseema Hoosainny ☐ First Available Physician

Reasons for Referral:

Infertility

☐ Infertility ☐ Recurrent Pregnancy Loss

General Gynecology

☐ Pediatric/Adolescent Gynecology ☐ IUD Insertion ☐ PCOS
☐ Menopause/Perimenopausal Concerns ☐ PAP Smear ☐ Contraception Counselling

Other: _____

Please enclose any relevant blood work, imaging, operative reports or consultations

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