



Westend Centre for Assisted Reproduction

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WESTEND CENTRE FOR ASSISTED REPRODUCTION LIMITED

To: Dr Shruti Gandhi
Date of Consultation

Patient Name: _____
OHCN Number _____
Date of Birth _____

This form is to be completed by the referring physician.

- A: Reason for Referral:
- B: Relevant History:
- C: Physical Examination:
- D: Investigation:(Please Enclose Copy of Any Diagnostic Reports)
- E: Medications:
-

Requested By: _____ Telephone: _____
Address : _____ Fax No: _____
Signature : _____ Ohip Physician # _____
Date _____