



**Dr. Rolando R. Cepeda MD, FRCSC**

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## Referral Form

Please fax or mail this completed form to HART Fertility Centre

### PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

Health Card Number: \_\_\_\_\_ Version: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
Number Street

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

### REFERRING PHYSICIAN

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Billing/ Provider Number \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
Number Street

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

### REASON FOR REFERRAL

Please provide a brief description:

Doctor's Signature: \_\_\_\_\_ Billing #: \_\_\_\_\_