



Ontario Network  
of Experts in Fertility  
Mississauga

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**REFERRAL FORM | Please fax to 905-823-2013**

Patients will be contacted within 5-10 business days.

**REFERRAL TO:**

Dr. Heather Cockwell, BSc (Honors), MD, FRCSC

**PATIENT INFORMATION / Label**

**PARTNER INFORMATION / Label**

**REFERRING PHYSICIAN:**

NAME \_\_\_\_\_

OHIP Billing Number \_\_\_\_\_

Address \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Number Street Unit/Suite

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
City Province Postal Code

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**REASON FOR REFERRAL:**

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Signature Date

NOTE: Patients with previous sterilization procedures are not covered by OHIP for fertility care.