REFERRAL LETTER

Referring Doctor's Name: _____

Referring Phone/Fax: _____

Referring Doctor's OHIP Billing Number: _____

To: Dr. Judith Campanaro

Re: (Patient Name/Demographics) _____

Diagnosis: _____

Pertinent History and Tests:

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Fax Date: _____

Kitchener Area Reproductive Medicine Associates (KARMA)
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Tel: 519-570-0090 Fax: 519-570-3202