



Leading Edge Care. Close to Home.

Room 4427, East building, Level 4  
596 Davis Drive, Newmarket, Ontario L3Y 2P9  
Tel: 905-895-4521 ext 2724

Health Record #: _____	Complete or place patient label here
Patient Name: <i>(Print first, last)</i> _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

### Maternal Fetal Medicine Clinic Referral

Please complete and fax to 905-830-5804

REFERRING PHYSICIAN / MIDWIFE INFORMATION	
Name:	Phone Number:
Address:	Fax Number:
Email Address:	OHIP Billing Number:

PATIENT INFORMATION	
Name:	Phone Number:
Health Card Number:	Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>
Does the patient need translator? <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____	
Gestational Age _____ weeks	Maternal Age: _____ years EDC: <u>dd</u> / <u>mm</u> / <u>yy</u>
Reason for Referral: <input type="checkbox"/> Pregnancy Consult <input type="checkbox"/> Non-Pregnant Consultation	
Maternal Concerns: <i>Explain:</i>	
Fetal Concerns: <i>Explain:</i>	

**To process this referral, the following documentation is required:**

- Antenatal Records
- All relevant antenatal blood work
- FTS / IPS / MSS / NIPT Results
- Reports of abnormal findings in previous pregnancy or child (e.g. Ultrasound, autopsy, chromosomes)
- Ultrasound Results
- Reports from other specialists involved in this patient's care
- Other lab tests pertinent for referral

**Our goal is always to provide care close to home. In some cases though timely care may be available sooner in Toronto at St. Micheal's Hospital. Please inform your patients.**

**FOR OFFICE USE ONLY**

Return to referring caregiver for further information/documentation

Book in Clinic in \_\_\_\_\_ wks  with Ultrasound  without Ultrasound

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