



Please **COMPLETE ALL OF THE FOLLOWING INFORMATION** and fax to: 613-739-6836

Referring Physician / Midwife Information

Name: _____ OHIP Billing Number: _____
Address: _____
Private Phone _____ Fax: _____
E-mail: _____ Date of Referral _____

PATIENT INFORMATION

Name: _____ Phone: _____
Date of Birth: _____ Health Card Number: _____
YYYY · MM · DD
Does patient need a translator? No Yes Language: _____
Previous referral to another specialty in **this pregnancy**? Specify: _____
Reason for Referral: Consult Transfer of Care Shared Care Pre-pregnancy/Post Loss Consult
Maternal Age: _____ yrs LMP: _____ EDC: _____ Gest. Age _____ wks
G ____ T ____ P ____ A ____ L ____
Maternal Concerns: Explain: _____

Fetal Concerns: Explain _____

N.B. - To process referral we NEED all the following documentation with Fax.

- 1) **Antenatal Records 1 & 2:** Sent with faxed referral:
- 2) **All relevant antenatal blood work:** Sent with faxed referral:
- 3) **FTS / IPS / MSS Results:** Sent with faxed referral: or Pt. has been counselled and will or will not proceed with Integrated Pre-natal Screening
- 4) **Ultrasound Results:** Sent with faxed referral:
- 5) **Reports from other specialist(s) involved in this patient's care:** Sent with faxed referral:
- 6) **Other lab results relevant for referral:** Sent with faxed referral:
- 7) **Reports of abnormal findings in previous pregnancy or child (e.g. Ultrasound, autopsy, chromosomes)**

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Internal Use - Date Referral Received: _____