SHN

High Risk Pregnancy Referral – Maternal Fetal Medicine

For Office Use:
- ☐ Within 1 week
- ☐ Within 2 weeks
- ☐ Within 1 month

Referral Date: _____
Appointment Date: _____

REFERRING PHYSICIAN

Name: _____ **Physician Billing #:** _____

Phone: _____ Fax: _____ **Delivery Hospital:** _____

PATIENT INFORMATION

Name: _____ Phone: ( ) _____-_____/H

Address: _____ ( ) _____-_____/B

City: _____ Postal code: _____ ( ) _____-_____/C

Date of Birth: _____/____/____ (yyyy mm dd) Health Card # _____ vers.

Is Patient Pregnant? Yes ☐ No ☐ Multiple Pregnancy Yes ☐ (type_____) No ☐

If yes, EDD _____/____/____ (yyyy mm dd) Ultrasound _____/____/____ (yyyy mm dd) CRL ____mm BPD ____mm

REASON FOR REFERRAL

Maternal Concerns: _____

_____

Fetal Concerns: _____

_____

Pertinent Medical/Obstetric/Family History: _____

_____

Referral MD Signature: _____

INVESTIGATIONS

Previous Genetics/MFM Consultation? Yes ☐ No ☐ If yes, where? _____

Please forward the following reports with referral: *Antenatal Records *Ultrasound Results *Lab Results (CBC, BI Grp.) *FTS/IPS/MSS Results

Fax Form to (416) 281-7027– Referrals will not be processed until all required information is received.
For further inquiries, call (416) 284-8131 extension 4047. Please print copies as needed.