



Name: _____

Place Patient Barcode Label Here

HIGH RISK PREGNANCY REFERRAL FORM

Maternal Fetal Medicine & Genetics Clinic

MFM Telephone: 905-883-1212 / 905-832-4554 Ext. 3069

Prenatal / Genetics Telephone: 905-883-1212 / 905-832-4554 Ext. 7579

Fax: 905-883-2052

Date: _____ (dd/mm/yyyy)

***Referrals will only be processed upon receipt of a completed form. Please ensure to include all supporting documents**

Select Service for Referral		
<input type="checkbox"/> MFM (Dr. Torrance)	<input type="checkbox"/> Genetics (Dr. Wyatt)	<input type="checkbox"/> Fetal Cardiology/Echo (Dr. Jevremovic)
<input type="checkbox"/> OB Medicine (Dr. Bensoussan)	<input type="checkbox"/> NAC (Dr. Gryn / Dr. Kirtsman)	

Patient Information			
Patient Name: _____ <small>(Print Last, First)</small>		Date of Birth: _____ <small>(dd/mm/yyyy)</small>	
Main Telephone Number: _____		Alternate Phone Number: _____	
Address: _____ <small>Street or Apt#</small>		_____ <small>City/Town</small>	_____ <small>Province</small>
		_____ <small>Postal Code</small>	
Health Card Number: _____		Version Code: _____	

Referral Physician			
Physician Name: _____ <small>(Print Last, First)</small>		Physician Signature _____	
Billing #: _____			
Telephone Number: _____		Fax Number: _____	
_____ <small>Street:</small>		_____ <small>Apt:</small>	_____ <small>City/Town</small>
		_____ <small>Province</small>	
Address: _____ <small>Postal Code</small>			

Patient Pregnancy Information		
LMP Date: _____ <small>(dd/mm/yyyy)</small>	EDD Date: _____ <small>(dd/mm/yyyy)</small>	Gestational Age: _____

***Please send dating ultrasound if available**

Reason for Referral	
<input type="checkbox"/> Prenatal Screening: 11 – 13 weeks, Nuchal Translucency Ultrasound and Integrated Prenatal Screening blood work <input type="checkbox"/> Fetal Anatomy Ultrasound: 19 – 2- weeks <input type="checkbox"/> Biophysical profile / Doppler <input type="checkbox"/> Fetal Growth <input type="checkbox"/> Fetal Echo <input type="checkbox"/> Placental Assessment <input type="checkbox"/> OB Medicine Consult <input type="checkbox"/> NAC Consult	
<input type="checkbox"/> Maternal Concerns: <i>(Please explain)</i> 	<input type="checkbox"/> Fetal Concerns: <i>(Please explain)</i>

Supporting Documents Included	
<input type="checkbox"/> Ultrasounds <input type="checkbox"/> Specialists Reports <input type="checkbox"/> Antenatal Forms <input type="checkbox"/> Abnormal Findings <input type="checkbox"/> Blood Work <input type="checkbox"/> First Trimester Screening <input type="checkbox"/> Integrated Prenatal Screening <input type="checkbox"/> Maternal Serum Screening Results	

PLEASE BE ADVISED: Our clinic will notify your patient of the appointment details, and all reports will be forwarded to your office. Appropriate follow-up will be arranged when necessary.

