

HIGH RISK PREGNANCY REFERRAL FORM

Maternal Fetal Medicine & Genetics Clinic

MFM Telephone: 905-417-2000 Ext. 5451

Prenatal / Genetics Telephone: 905-883-1212 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. Aul)	<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			
<i>(Print Last, First)</i>		<i>(dd/mm/yyyy)</i>	
Patient Name:		Date of Birth:	
Main Telephone Number:		Alternate Phone Number:	
<i>Street or Apt#</i>	<i>City/Town</i>	<i>Province</i>	<i>Postal Code</i>
Address:			
Health Card Number:		Version Code:	

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

Patient Pregnancy Information			
LMP Date:	<i>(dd/mm/yyyy)</i>	EDD Date:	<i>(dd/mm/yyyy)</i>
		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"/> Fetal Echo <input type="checkbox"/> NAC Consult	
<input type="checkbox"/> Biophysical profile / Doppler <input type="checkbox"/> Placental Assessment	
<input type="checkbox"/> Fetal Growth <input type="checkbox"/> OB Medicine 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.



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