

# 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. 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<br><input type="checkbox"/> Fetal Anatomy Ultrasound: 19 – 2- weeks<br><input type="checkbox"/> Fetal Echo<br><input type="checkbox"/> NAC Consult |  |
| <input type="checkbox"/> Biophysical profile / Doppler<br><input type="checkbox"/> Placental Assessment  |  |
| <input type="checkbox"/> Fetal Growth<br><input type="checkbox"/> OB Medicine Consult  |  |
| <input type="checkbox"/> Maternal Concerns: <i>(Please explain)</i><br><br><br>  | <input type="checkbox"/> Fetal Concerns: <i>(Please explain)</i><br><br><br> |

| 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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