**Maternal-Fetal Medicine**
**London Health Sciences Centre – Victoria Hospital**
**800 Commissioners Road East, London, ON**
**☎ (519) 646-6106 FAX (519) 646-6213**
**Drs. B. de Vrijer, G. Hardy, R. Gratton, G. Eastabrook, and J. Schmidt**

## Referring Physician / Midwife Information

Name: _____

Address: _____ Billing Number: _____

Phone: (_____)_____ Fax: (_____)_____

## Patient Information

Name: _____ Phone: (_____)_____

Date of Birth: _____ Health Card Number: _____
M · DD - YY

Does patient need translator? ☐ No ☐ Yes Language: _____

Did patient require referral to another specialty this pregnancy? If yes, specify: _____

**Reason for Referral**: ☐ Consult ☐Transfer of Care

EDB: Gestational Age: wks

**Maternal Concern/s**

**Fetal Concern(s)**

**To process this referral, the following documentation is required:**
☐ Ontario Antenatal Records
☐ Routine antenatal blood work
☐ Prenatal Screening (FTS/IPS/MSS)
☐ Ultrasound Results (early and morphology)
☐ Reports of abnormal findings in previous pregnancy or child (i.e. ultrasound, autopsy)
☐Other:_____

**Please continue to see your patient for regular prenatal care until she has her appointment.**