

Maternal-Fetal Medicine
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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.

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