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Regional Prenatal Services

1200 Main St. West, Hamilton, ON L8N 3Z5 Fourth Floor

Regional Prenatal Diagnosis Service **2F Clinic** Counselling Office: (905) 521-2100, x76247 Clinic Referrals: ☎ (905) 521-2649 **Fax (905) 521 - 4955**	**Maternal - Fetal - Medicine** **4F Clinic** ☎ (905) 521-2644 **Fax (905) 527-0602**

Please complete all of the following information and FAX to the appropriate clinic.

Referring Physician / Midwife Information

Name: ______________________________ OHIP Billing Number: ______________

Address: ____

Phone: (_____)__________ Fax: (_____)__________ E-mail: ______________

Patient Information

Name: ______________________________ Phone: (_____)__________

Address: ______________________________ Postal Code: ________

Date of Birth: ______________ (YYYY · MM · DD) Health Card Number: ______________ VERSION CODE

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

Previous referral to another specialty in this pregnancy? Specify: ______________

Reason for Referral: ☐ Consult ☐ Transfer of Care ☐ Non-Pregnant Consultation

Maternal Age: ______ yrs LMP: __________ EDB: __________ Gest. Age ______ wks

Maternal Concerns:
Explain:

Fetal Concerns: ☐ Positive Prenatal Screening Results (attach reports) ☐ Abnormal Ultrasound Results
☐ Previous pregnancy or child with abnormality (attach info) ☐ Family history of ______________(attach info)
Explain:

To process this referral, the following documentation is required:

☐ Antenatal Records ☐ FTS / IPS / MSS Results ☐ Ultrasound Results *(All referrals for LMA must include a dating ultrasound)*
☐ Specialist Reports involved in this patient's care ☐ Other lab tests pertinent for referral
☐ All Antenatal blood work *(CBC, Rh, Group & Antibody Screen, Hep B, VDRL, Rubella, HIV)*
☐ Reports of abnormal findings in previous pregnancy or child *(e.g. Ultrasound, autopsy, chromosomes)*

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