The Ottawa Hospital | L'Hôpital d'Ottawa

Maternal-Fetal Medicine
The Ottawa Hospital - General Campus
501 Smyth Road, Box 241, Ottawa, ON K1H 8L6
Direct 613-737-8595

born Ontario — Early health. Lifelong health. Début en santé. Longue vie en santé.

Please *COMPLETE ALL OF THE FOLLOWING INFORMATION* and fax to: 613-739-6836

Referring Physician / Midwife Information

Name: _____ OHIP Billing Number: _____

Address: _____

Private Phone _____ Fax: _____

E-mail: _____ Date of Referral _____

PATIENT INFORMATION

Name: _____ Phone: _____

Date of Birth: _____ Health Card Number: _____
YYYY · MM · DD

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

Previous referral to another specialty in **this pregnancy**? Specify: _____

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

Maternal Age: _____yrs LMP: _____ EDC: _____ Gest. Age _____wks

G _____ T _____ **P** _____ **A** _____ **L** _____

Maternal Concerns: Explain: _____

_____

_____

_____

Fetal Concerns: Explain _____

_____

_____

_____

N.B. - To process referral we NEED all the following documentation with Fax.

1) **Antenatal Records 1 & 2:** Sent with faxed referral: ☐
2) **All relevant antenatal blood work:** Sent with faxed referral: ☐
3) **FTS / IPS / MSS Results:** Sent with faxed referral: ☐ or Pt. has been counseled and will ☐ or will not ☐ proceed with Integrated Pre-natal Screening
4) **Ultrasound Results:** Sent with faxed referral: ☐
5) **Reports from other specialist(s) involved in this patient's care:** Sent with faxed referral: ☐
6) **Other lab results relevant for referral:** Sent with faxed referral: ☐
7) **Reports of abnormal findings in previous pregnancy or child (e.g. Ultrasound, autopsy, chromosomes)**

Internal Use - Date Referral Received: _____