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MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

Special Pregnancy Program (SPP)

Ontario Power Generation Building, 3rd Floor, 700 University Avenue, Toronto, Ontario M5G 1Z5

☎ **416-586-8808 (Press 1 – Maternal Diseases; Press 2 – Fetal Medicine)**

Please complete ALL of the following information and fax to: 416-586-3216

Referred to (Physician's Name): _____

Referring Physician / Midwife Information

Name: _____ Hospital: _____

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

E-mail: _____

Patient Information

Name: _____ Phone: (_____)_____

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

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 EDC: _____ Gest. Age _____ wks

Maternal Concerns: ❑ Previous problem ❑ Current Problem

❑ Gest. HTN ❑ Diabetes ❑ Other: _____
Explain:

Fetal Concerns: ❑ Previous problem ❑ Current Problem

❑ IUGR ❑ Fetal Anomalies ❑ PPROM ❑ PTB at _____weeks ❑ Alloimmunization
❑ Other: _____
Explain:

To process this referral, the following documentation is required:

❑ Antenatal Records
❑ All relevant antenatal blood work
❑ FTS / IPS / MSS Results
❑ Ultrasound Results
❑ Reports from other specialists involved in this patient's care
❑ Other lab tests pertinent for referral
❑ Reports of abnormal findings in previous pregnancy or child *(e.g. Ultrasound, autopsy, chromosomes)*