

URGENT REFERRALS (appointment within 48 hours), **page MFM on call (905-521-5030)**

NON URGENT REFERRALS: These will **Not Be Processed** until the following information is received:

- An **ULTRASOUND** showing a **VIABLE** pregnancy (i.e. fetal heart rate & crown rump length --usually at 7-8 weeks)
- All** subsequent ultrasounds
- Prenatal lab results, if not yet completed please **arrange** and **forward** when available. Date sent: _____
- All lab results pertinent to the referral (e.g. HbA1C for diabetes)
- Specialist Consultations and associated lab results if patient cared for by additional physicians

Pre- Pregnancy Consultation (i.e. pregnancy planning)

- relevant history including any specialist consults and associated lab results
- an indication of how soon patient plans to attempt pregnancy _____

Referring Physician /Midwife

Name _____ Billing Number _____

Phone _____ FAX _____ Private line _____

Patient Information

Name _____ Phone _____

Address _____ Postal code _____

DOB (dd/mm/yyyy) _____ Health card number _____

Does patient need a translator? no yes IF yes, language spoken _____

LMP (dd/mm/yyyy) _____ EDC _____ Gest. Age _____ wks

Other Specialist involved with patient _____ Reason _____

Other Specialist involved with patient _____ Reason _____

Reason for referral **Date:** _____