

Women & Babies Clinic Referral Form

2075 Bayview Avenue, M-Wing, 4th floor
Toronto, Ontario M4N 3M5
Telephone (416) 480-5367

Fax to: (416) 480-5616

(Check all that apply)

Referred to: Dr. _____ ☐ High Risk Clinic ☐ Consult ☐ Transfer of Care

Referring Physician / Midwife / Nurse Practitioner

Name _____ OHIP Billing Number _____
Phone _____ Fax _____

Patient Information

Name _____ Date of Birth _____
Phone _____ Health Care Number _____

Reason for Referral

Maternal age _____ LMP _____ EDC _____ Gestational age _____ wks

☐ Maternal concerns:

☐ Fetal concerns:

To process this referral, the following documentation must be provided:

- | | |
|---|--|
| <input type="checkbox"/> Antenatal Records | <input type="checkbox"/> Ultrasound results |
| <input type="checkbox"/> FTS/IPS/MSS results | <input type="checkbox"/> All relevant antenatal blood work |
| <input type="checkbox"/> Reports from other specialists | <input type="checkbox"/> All lab tests related to referral |
| <input type="checkbox"/> Reports of abnormal findings in previous pregnancy or child (eg. <i>Ultrasound, autopsy, chromosomes</i>) | |