HUMBER RIVER HOSPITAL

Obstetrical Outpatient Clinic-Referral Form

Please select the clinic for referral and complete referral below			
Obstetrical General Medicine Clinic ☐	Non stress Test Clinic ☐	Pre-surgical Screening ☐	
Early pregnancy Clinic ☐	Postpartum Wellness ☐	Postpartum assessment ☐	Maternal Fetal Medicine clinic ☐
Referring Physician:		Signature:	
Main Contact number:		Email:	
Billing number:			
Attached all antenatals, Diagnostic reports, and applicable history, and medication lists ☐ Yes ☐ No		G:__P:___A:___L:___ EDD (mm/dd/yy):_____	

Obstetrical Medicine Clinic

Select indication for referral (patients can also be seen for pre-pregnancy and postpartum assessment/follow-up)

- ☐ Pregnancy Induced Hypertension
- ☐ Essential Hypertension
- ☐ Liver disease
- ☐ Cardiac disease
- ☐ Stroke
- ☐ VTE-Venous thromboembolism
- ☐ Cholestasis
- ☐ Other:

_____

☐ Maternal history/concerns:

_____

☐ Fetal concerns:

_____

☐ History of complication in pregnancy:

_____

Existing medical issue ☐ Yes ☐ No

Patient being followed by a medical prac oner

☐ Yes ☐ No

Non-Stress Test Criteria

Indication for NST must be completed

- ☐ Diabetes
  - ☐ Pre-existing: weekly NST starting at 30 weeks
  - ☐ GDM On Insulin: weekly NST starting at 36 weeks
- ☐ Hypertension (HTN) + preeclampsia or IUGR
- ☐ Oligohydramnios
  - Weekly from diagnosis
- ☐ Polyhydramnios
  - Biweekly from time of diagnosis to 37 weeks, then weekly to delivery
- ☐ Previous Stillbirth
  - Weekly from 2 weeks prior to previous stillbirth (titart at 32 weeks at the latest)
- ☐ Maternal Age over 40 yr (AMA)
  - Weekly from 36 weeks
- ☐ IVF
  - Starting at 36 weeks
- ☐ IUGR
- ☐ OTHER

_____

Pre-surgical Screening

- ☐ Patient requires surgical pre-screening
- ☐ Patient requires anaesthetic consultation
- ☐ Patient can be given a outpatient requisition to have blood drawn in the outpatient lab

Complete pertinent Surgical history on antenatals and review patient questonnaire

Early Pregnancy Clinic

LMP (mm/dd/yy): _____

- ☐ **Abortion**
  - ☐ Missed
  - ☐ Incomplete
  - ☐ Threatened
- ☐ **Ectopic**

Methotrexate given (mm/dd/yy): _____

Postpartum Wellness

- ☐ Patient requires support postpartum
- ☐ Patient requires support from postpartum adjustment program
- ☐ Patient would benefit from additional support and mental health adjustment

Please complete perinatal social referral form and attach

Breastfeeding Clinic

Prenatal and postnatal patients do not require referral-all patients will receive referral for 2-3 days after discharge

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