Ontario Neonatal Follow-Up Program Referral Form

Birth hospital:

Hospital transferred from:

1st appointment: YYYY/MM/DD

Appointment handout given: Y/N

Follow-up referral made to: see reverse for programs

Shared care eligible: Y/N

Current Name:	Age at Birth: _____weeks_____days
Birth Surname:	Weight: _____grams
Expected Due Date: YYYY/MM/DD	DOB: YYY/MM/DD
Date of discharge home: YYY/MM/DD	
Parent's (1) Name:	Phone (Home):
Address:	Phone (Cell):
Parent's (2) Name:	Phone (Home):
Address: Same as above Y/N	Phone (Cell):
Community primary practitioner:	

Criteria for Follow-Up Program

(as per Neontal Follow-Up Levels of Care, www.pcmch.on.ca)

[ ] Regional NICU	[ ] Tertiary Care NICU
[ ] Gestational age between 30 0/7 weeks to 33 6/7 weeks	[ ] Gestational age < 30 weeks
[ ] BW or HC less than 3rd percentile	[ ] Bronchopulmonary dysplasia (defined as O2 requirement at 36 weeks
[ ] Hyperbilirubinemia at exchange transfusion level for gestational age	[ ] HIE Sarnat Level 2 or 3 (moderate or severe encephalopathy
[ ] Symptomatic hypoglycemia <2.2mMol over 6h requiring intensive monitoring	[ ] Therapeutic hypothermia
[ ] IUD of a twin if surviving twin born <36 6/7 weeks	[ ] IVH >III
[ ] Other:	[ ] Meningitis (fungal or bacterial)
	[ ] Necrotizing enterocolitis (requiring surgery)
	[ ] Neonatal stroke
	[ ] Viral encephalitis requiring NICU tertiary care
	[ ] Complex congenital anomalies (requiring >2 medical providers)
	[ ] Complex surgical cases (requiring >2 providers)
	[ ] Other:

Criteria for Referral

[ ] NICU discharge summary attached

Referring MD:

Billing number:

Contact information for referring MD:

Form # 001708, version (04-2018)