Humber River Hospital

Obstetrical Outpatient Clinic-Referral Form

Affix Patient Label here
Patient Name: _____
Address: _____
Phone number: _____
Hospital #_____

Please select the clinic for referral and complete referral below				
Obstetrical General Medicine Clinic ☐	**Non stress Test Clinic** ☐	**Pre-surgical Screening** ☐ **Anaesthetic consult** ☐		**Celestone injection** ☐ **WinRho injection** ☐
Early pregnancy Clinic ☐	**Social Work** ☐ **Postpartum Wellness** ☐	**Postpartum assessment** ☐	**Dietician** ☐	**PreNeph 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 practitioner
☐ 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 32 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 (start at 32 weeks at the earliest)

☐ 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
☐ **Completed pertinent surgical history on antenatals and review patient questionnaire**

PreNeph Clinic

☐ Nephrology Care in Pregnancy

Early Pregnancy Clinic (less than 13 weeks)

LMP (mm/dd/yy): _____

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

☐ **Ectopic**
Methotrexate given (mm/dd/yy): _____
Misoprostol 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
☐ **Complete perinatal social referral form and attach with referral**

Breastfeeding Clinic

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

Other Referral (please specify):

_____

Form # 103225, version (01-2021)

Please be advised: patients will receive a call from the Obstetrical clinic to book as appropriate, please ensure all contact information is correct and verified

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