

Maternal Fetal Medicine Clinic Referral

☎ 416 242 1000 ext: 21450

Humber River Health, 1235 Wilson Avenue, Toronto ON M3M 0B2

Please complete all of the following information and fax to: 📠 416-242-1137

Referring Physician / Midwife Information

Name: _____	Phone: (____) _____
Address: _____	Fax: (____) _____
E-mail: _____	OHIP Billing Number: _____

Patient Information

Name: _____	Phone: _____	Date of Birth: _____ (DD/MM/YY)
Health Card Number: _____		
Does the patient need translator? Yes <input type="checkbox"/> No <input type="checkbox"/> Language: _____		
Gestational Age _____ weeks	Maternal Age: _____ years	EDC: _____ (DD/MM/YY)
Reason for Referral: <input type="checkbox"/> Consult Maternal <input type="checkbox"/> Non-Pregnant Consultation		
Concerns: Explain:		
Fetal Concerns: Explain:		

To process this referral, the following documentation is **required**:

- | | |
|--|--|
| <input type="checkbox"/> Antenatal Records | <input type="checkbox"/> Ultrasound Results |
| <input type="checkbox"/> All relevant antenatal blood work | <input type="checkbox"/> Reports from other specialists involved in this patient's |
| <input type="checkbox"/> FTS / IPS / MSS / NIPT Results | <input type="checkbox"/> care Other lab tests pertinent for referral |
| <input type="checkbox"/> Reports of abnormal findings in previous pregnancy or child (e.g. <i>Ultrasound, autopsy, chromosomes</i>) | |

For Office Use Only

Return to referring caregiver for further information/documentation

Book in HRC in _____ wks with Ultrasound without Ultrasound

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