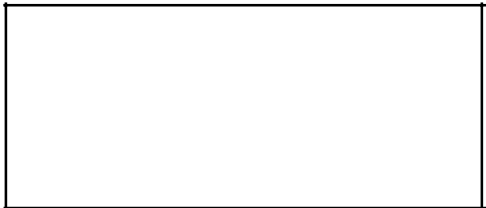


# Obstetrical Outpatient Clinic-Referral Form



Please select the clinic for referral and complete referral below

Obstetrical General Medicine Clinic <input type="checkbox"/>	Non stress Test Clinic <input type="checkbox"/>	Anaesthetic Consult <input type="checkbox"/>	WinRho injection <input type="checkbox"/> Celestone injection <input type="checkbox"/>
Early Pregnancy Clinic <input type="checkbox"/>	Perinatal Wellness <input type="checkbox"/>	Dietician <input type="checkbox"/>	PreNePH Clinic <input type="checkbox"/>

Referring Physician: \_\_\_\_\_ Signature: \_\_\_\_\_

Main Contact number: \_\_\_\_\_ Email: \_\_\_\_\_

Billing number: \_\_\_\_\_

Attach all antenatals, Diagnostic reports, and applicable history, and medication lists:  
 Yes  No

G: \_\_ P: \_\_ A: \_\_ L: \_\_  
 EDD (dd/mm/yy): \_\_\_\_\_

**Obstetrical Medical Clinic**

Select indication for referral

- Pregnancy Induced Hypertension
- Essential Hypertension
- Liver Disease
- Cardiac Disease
- Stroke
- VTE – Venous thromboembolism
- Cholestasis
- Other: \_\_\_\_\_

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Maternal history/concerns: \_\_\_\_\_

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History of complication in pregnancy: \_\_\_\_\_

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Existing medical issue:  Yes  No

Patient being followed by a medical practitioner

Yes  No

**NOTE: Please send in bloodwork.**

**Non-Stress Test Criteria**  
 Indication for NST must be completed

**Diabetes**

- Medically treated GDM (i.e. Insulin)
- Poorly controlled GDM
- Pre-existing Diabetes
- Pre-existing Hypertension
- Pre-eclampsia/ Gestational Hypertension (PIH)
- Cholestasis
- Multiples  mono/di  di/di
- Abnormal fetal doppler
- Oligohydramnios
- Polyhydramnios
- IUGR
- Previous Stillbirth
- Advanced Maternal Age (AMA)
- OTHER: \_\_\_\_\_

Start date: \_\_\_\_\_

Frequency:

- Weekly
- Bi-Weekly
- Other: \_\_\_\_\_

**PreNeph Clinic**

Nephrology Care in Pregnancy

**Perinatal Wellness**

Reason: \_\_\_\_\_

**NST Clinic does not book BPP unless indicated by an abnormal NST.**

**If a scheduled BPP is required, fax referral to Medical Imaging at 416-242-1078.**

**Other Referral (please specify):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Maternal Fetal Medicine Clinic Referral**

**Complete the Maternal Fetal Medicine Clinic Referral form located on:**  
<https://www.hrh.ca/programs/maternal-child-care/>

Form # 103225, version (11-2021)