McMaster University Medical Centre
WOMEN'S REPRODUCTIVE HEALTH AND NEWBORN CARE

Maternal Fetal Medicine Service Referral Form

Drs. DeFrance, Morais, Nourallah, Osmond, Sharma, Smith, Winsor
4B1 Clinic: Phone 905 521-2644 FAX 905 527-0602

URGENT REFERRALS (appointment within 48 hours), **page MFM on call (905-521-5030)**

NON URGENT REFERRALS: These will **Not Be Processed** until the following information is received:

- □ An **ULTRASOUND** showing a **VIABLE** pregnancy (i.e. fetal heart rate & crown rump length --usually at 7-8 weeks)
- □ ***All*** subsequent ultrasounds
- □ Prenatal lab results, if not yet completed please ***arrange*** and ***forward*** when available. Date sent:_____
- □ Ontario Prenatal records 1,2,3
- □ All lab results pertinent to the referral (e.g. HbA1C for diabetes)
- □ Specialist Consultations and associated lab results if patient cared for by additional physicians

Pre- Pregnancy Consultation (i.e. pregnancy planning)

- □ relevant history including any specialist consults and associated lab results
- □ an indication of how soon patient plans to attempt pregnancy_____

Referring Physician /Midwife

Name _____ Billing Number_____

Phone_____ FAX_____ Private line_____

Patient Information

Name _____ Phone _____

Address _____Postal code_____

DOB (dd/mm/yyyy) _____ Health card number _____

Does patient need a translator? □ no □ yes IF yes, language spoken_____

LMP (dd/mm/yyyy) _____ EDC _____ Gest. Age_____wks

Other Specialist involved with patient _____Reason _____

Other Specialist involved with patient _____Reason _____

Reason for referral **Date: _____**