

Maternal-Fetal Medicine  
London Health Sciences Centre- Victoria Hospital  
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Referring to: \_\_\_\_\_

### Referring Physician/Midwife Information

Referring Physician/Midwife: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Health Card Number: \_\_\_\_\_  
YYYY · MM · DD

Does patient require translator?  Yes  No Language \_\_\_\_\_

Did patient require referral to another specialty in this pregnancy? If yes, specify: \_\_\_\_\_

Reason for Referral:

EDB: \_\_\_\_\_ Gestational age: \_\_\_\_ Weeks \_\_\_\_ Days \_\_\_\_ TPAL \_\_\_\_\_

**Maternal Concerns:**

**Fetal concerns:**

**The following documentation is required before this referral can be processed:**

- Routine antenatal blood work
- Prenatal screening (EFTS/MSS/NIPT)
- Ultrasound results (early and morphology)
- Reports of abnormal finding in previous pregnancy or child (i.e. ultrasound or autopsy)
- Most recent pap smear
- Other: \_\_\_\_\_

**Please continue to see your patient for regular prenatal care until she has her appointment.**

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