Referral Form- Pregnancy Options Program

Women's Health Care Centre Rm B5-372 (Pod 5)	**Office Use Only**
LHSC Victoria Hospital	Date Received: _____
800 Commissioners Road East	Appointment Dates: 1:_____ 2:_____
London Ontario N6A 5W9	
Phone: (519) 685-8204	Procedure Date: _____
Fax: (519) 685-8164	

This form is used for screening purposes as well as to contact patients directly for their CONSULTATION APPOINTMENT. Please provide all information below and attach all pertinent documentation (Ultrasounds, genetic testing results, consult notes). Indicate below what type of referral this is for:

☐ Genetic Patient ☐ Early Pregnancy Loss Patient ☐ Elective Termination

Patients Name: _____

Date of Birth: _____

Health Card Number: _____

Address: _____

Telephone Number: _____ (Home/Cell) Patient Email: _____

Alternate Telephone Number: _____ (Home/Cell)

Referring Provider: _____ Date of Referral: _____

Provider Telephone: _____ Fax: _____ OHIP Billing # _____

Reason for Referral/ Genetic Diagnosis:

_____

Gestational Age at Time of Referral: _____

Diagnostic Testing Performed and Result:

Ultrasound: _____

IPS/ FTS: _____ CVS: _____

Amniocentesis: _____ NIPT: _____

Maternal Health History:

GTPAL: __ __ __ __ __ # Previous Vaginal Birth: ___ # Previous Cesarean: ___ Maternal Medical Conditions (Active):

_____

_____